

2324

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52</u> TOWN <u>Catonsville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14</u> <u>Spring Grove State Hosp.</u>		STREET ADDRESS (If rural give location) <u>Baltimore County Home</u>	1
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>El</u> <u>Albans</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>3</u> <u>24</u> <u>19 55</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>6-1-1978</u>
9. AGE last birthday <u>76</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>USA</u>
13. FATHER'S NAME: <u>unknown</u> <u>El; S. Alban.</u>		14. MOTHER'S MAIDEN NAME: <u>unknown</u> <u>Elizabeth Bull.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service) <u>no record</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT & ADDRESS: <u>Hospital's records</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>422.1</u> <u>Cerebral vascular accident</u>		<u>3 days</u>	
ANTECEDENT CAUSE (B) <u>Arteriosclerotic cardio-vascular disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>Feb. 23, 19 55</u> to <u>3-24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3-24</u> , 19 <u>55</u> , and that death occurred at <u>12:15 P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>G. Wachler</u>		DATE SIGNED <u>4/8/55</u>	
M. D. <u>Spring Grove St. Hospital</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>March 26, 19 55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Pine Grove Cemetery</u>		<u>Parkton, Balto. Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
<u>3/24/55</u>		<u>J. Jacobson, New Freedom, Pa.</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAR 29 1963

RECEIVED

2310

02297

## MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 41

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>Balt.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> LENGTH OF STAY (in this place) <u>4 1/2 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> 53	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3218 MC SHANE WAY</u>		STREET ADDRESS (If rural, give location) <u>3218 MC SHANE WAY</u>	
3. NAME OF DECEASED (Type or Print) <u>ELIZABETH ANN AMOS</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 29 1955</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MAY 5 1877</u> 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>OHIO</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>PICKENS</u>		14. MOTHER'S MAIDEN NAME <u>BELLE LAINE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>HOWARD W. AMOS 4112 BEALL ST</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Hypertensive Cardio-Vascular Disease</u>		
(b) Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Disease</u>		
(c) 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	PLACE (Home, farm, factory, street, OF office (Hdg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE M. S. Davis M.D. (Degree or title) ADDRESS 2112 Dundalk rd DATE SIGNED 3/30/55

23. RIAL CREMATION BURIAL DATE THEREOF APR 1 1955 NAME OF CEMETERY OR CREMATORY OAK LAWN LOCATION (City, town, or county) (State) COLGATE MD

DATE RECD BY LOCAL REGISTRAR'S SIGNATURE March 31 1955 William M. Kelley 24. FUNERAL DIRECTOR ULLRICH FUNERAL HOME 2112 DUNDALK ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 4 1955

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2325

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02298

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

Items 12, 13, 14 FilmG179 3-18-55 et

1. PLACE OF DEATH - COUNTY <b>Balto. Co. Md.</b> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <b>Md.</b> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Logan Village</b>				CITY (If outside corporate limits, write RURAL and give nearest town) <b>Balto. City</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>3492 Logan View</b>				STREET ADDRESS (If rural, give location) <b>1401 Filbert St.</b>			
3. NAME OF DECEASED (First) (Middle) (Last) <b>Elizabeth Bagdan (Bagdoniene)</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>Mar. 10, 55</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <b>Widowed</b>		8. DATE OF BIRTH <b>1874</b>	
9. AGE last birthday <b>81</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>				16. SOCIAL SECURITY No. <b>-</b>			
17. INFORMANT AND ADDRESS <b>Nellie Salkoski 4201 Grace Ct.</b>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
578X Immediate cause (a) <b>Massive Intestinal Hemorrhage</b>						4 days	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last							
II. OTHER SIGNIFICANT CONDITIONS (c) Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)				20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>				(CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>m.</b>				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>			
HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <b>5 Mar. 1955</b> to <b>10 Mar. 1955</b> , that I last saw the deceased alive on <b>10 Mar. 1955</b> , and that death occurred at <b>7:00 P</b> m., from the causes and on the date stated above.							
SIGNATURE <b>M. D. 3 Kingsley Rd. Balt. Md</b>				DATE SIGNED <b>12 Mar 55</b>			
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>				DATE THEREOF <b>3-15-55</b>			
NAME OF CEMETERY OR CREMATORY <b>Holy Cross</b>				LOCATION (City, town, or county) (State) <b>A.A. C.P. Md.</b>			
DATE REC'D BY LOCAL REG. <b>3/14/55</b>				24. FUNERAL DIRECTOR ADDRESS <b>Wm. S. Fialkowski 2007 Eastern Ave.</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **02299**  
**2311** CERTIFICATE OF DEATH  
 Reg. Dist. No. **41**

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Dundalk</u> TOWN <u>Dundalk</u> 3 years HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7731 Fairgreen Road</u>		STATE <u>Maryland</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> TOWN <u>Dundalk</u> STREET ADDRESS (If rural give location) <u>7731 Fairgreen Road</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Effie</u> <u>Miller</u> <u>Bailey</u> (Type or Print)		4. DATE OF DEATH: (Month) (Day) (Year) <u>March 29th, 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>10/4/89</u>
9. AGE last birthday: <u>65</u> yrs.		10. MONTHS <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired. <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Marcus Miller</u>		14. MOTHER'S MAIDEN NAME: <u>Sally Lester</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Raymond Dowdy, 7731 Fairgreen Rd. Dundalk, Md.</u>			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
<u>260X</u> Immediate cause (a) <u>Coronary Thrombosis</u> Antecedent causes (s) (b) <u>Myocarditis</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Diabetes Mellitus</u> DUE TO <u>10 min</u> <u>1 month</u> <u>5 years</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from the 1954 to March 29, 1955, that I last saw the deceased alive on March 29, 1955, and that death occurred at 1955, from the causes and on the date stated above.

SIGNATURE David A. Andrew (Degree or title) ADDRESS 33 Dundalk Ave DATE SIGNED 3/29/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4/2/55</u>	<u>Woodlawn Cemetery</u>	<u>Ironton, Ohio</u>	
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>March 29-1955</u>	<u>William M. Kelly</u>	<u>Walter Branch Bradley, Inc.</u>	<u>Dundalk, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 1 1945

RECEIVED

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2326

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

Reg. Dist. No. 37

1. PLACE OF DEATH COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lutherville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lutherville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Railroad Avenue</u>		STREET ADDRESS (If rural, give location) <u>Railroad Avenue</u>	
3. NAME OF DECEASED (Type or Print) <u>WILLIAM WALTER BAKER</u>		4. DATE OF DEATH <u>March 5, 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>July 10, 1900</u>
9. AGE last birthday <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Janitor</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Walter Baker</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Baker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Family Information</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>Heart disease - coronary occlusion</u> Antecedent cause(s) (b) <u>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>William C. Hudson M.D., D.M.E.</u>		DATE SIGNED <u>3/7/55</u>	
23. BURIAL, CREMATION REMOVAL, (Specify) <u>Burial</u>		DATE THEREOF <u>Mar. 8, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Towson, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>March 1955 Anne Annis MacRae</u>		24. FUNERAL DIRECTOR <u>John Burns &amp; Sons</u>	
		ADDRESS <u>Towson, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. M.

MAR 10 1955

RECEIVED



2327

## CERTIFICATE OF DEATH

Reg. Dist. No.

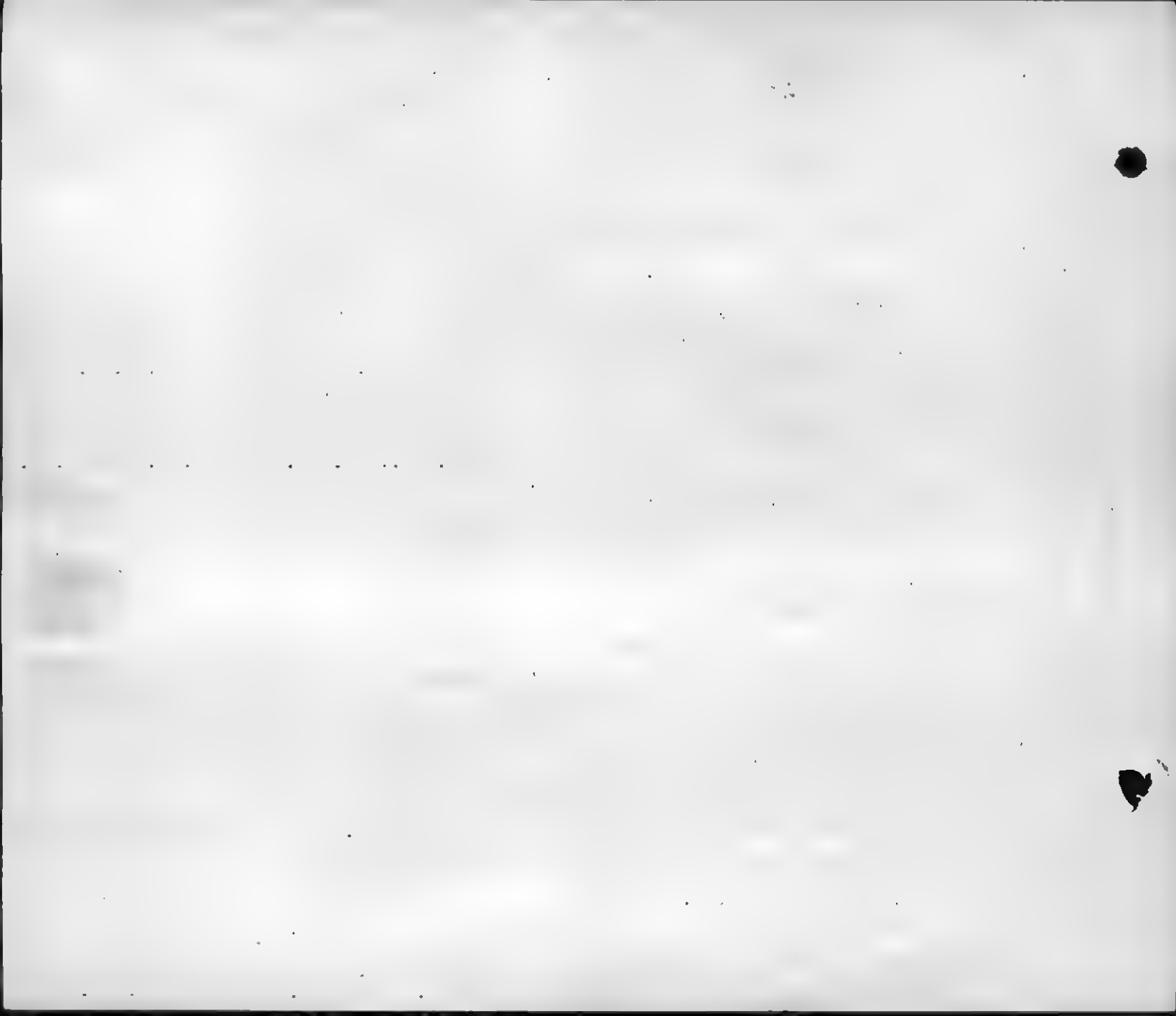
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <u>Fort Howard</u>		<u>21 Days</u>		TOWN <u>Reisterstown</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>46 Bond Avenue</u> /			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>REYNOLDS H. BALTIMORE</u>				OF DEATH: <u>March 23 19 55</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH: <u>October 6, 1887</u>	
						9. AGE last birthday <u>67</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Truck Driver</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Cement Company</u>		11. BIRTHPLACE (State or foreign country): <u>Front Royal, Virginia</u>	
13. FATHER'S NAME: <u>Turner Baltimore</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW-1</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>MYOCARDIAL INFARCTION</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u>			
ANTECEDENT CAUSE (B) <u>DUE TO CORONARY THROMBOSIS</u>				<u>2 WEEKS</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 2, 1955</u> , to <u>Mar. 23, 1955</u> , that I observed the deceased and that death occurred at <u>12:15 M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William B. VandeGrift, M.D.</u>				ADDRESS <u>M.D. VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>3-24-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/27/1955</u>		<u>Perney Grove Cemetery</u>		<u>Boring, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>March 26, 1955</u>		REGISTRAR'S SIGNATURE <u>R.W.</u>		24. FUNERAL DIRECTOR <u>Arlington S. Phillips Funeral Home</u>		ADDRESS <u>1808 N. Monroe St. Baltimore 17, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Delivered by Hearse by Phillips Funeral Home



# CERTIFICATE OF DEATH

Reg. Dist. No.

30

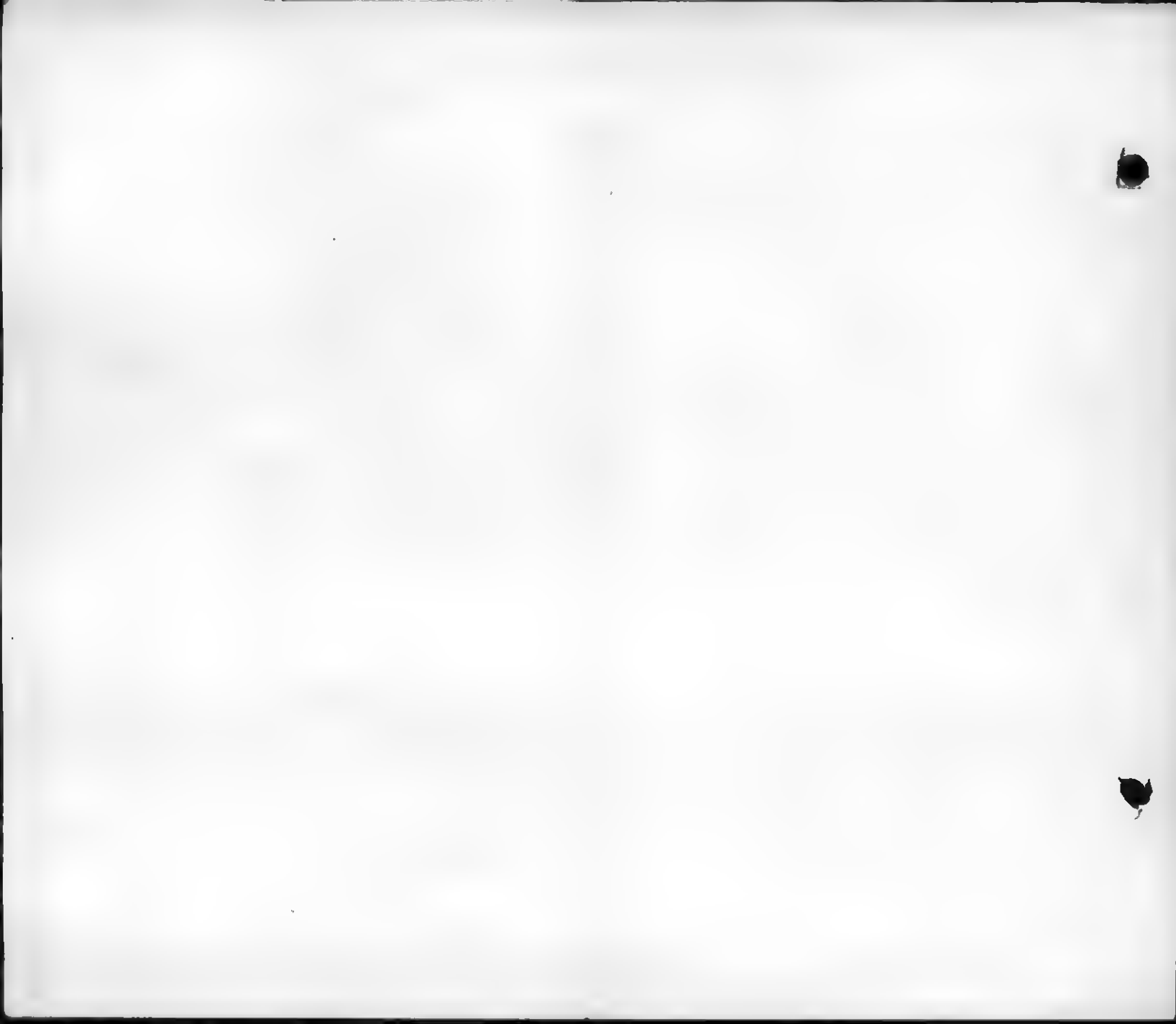
1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Baltimore</u>			STATE <u>Maryland</u> COUNTY _____		
CITY (If outside corporate limits, write RURAL, OR and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)		
<u>52</u> <u>Catonsville</u>		<u>2yr. 10mo. 8days</u>	<u>34</u> <u>Baltimore</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural give location)		
<u>14</u> <u>Spring Grove State Hospital</u>			<u>338 S. Mount Street</u> <u>✓</u>		
3 NAME OF DECEASED: (First) (Middle) (Last)			4. DATE (Month) (Day) (Year)		
<u>Sarah</u> <u>Haron</u> <u>Barber</u>			<u>OF</u> <u>March 9,</u> <u>1955</u>		
5. SEX: 6 COLOR OR RACE: 7. SINGLE MARRIED, WIDOWED, DIVORCED. (Specify): 8. DATE OF BIRTH:			9. AGE last birthday 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.		
<u>Female</u> <u>White</u> <u>Widowed</u> <u>8-22-1892</u>			<u>62</u> <u>Yrs.</u> <u>6</u> <u>Months</u> <u>0</u> <u>Days</u> <u>0</u> <u>Hours</u> <u>0</u> <u>Min.</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT COUNTRY?		
<u>Housewife</u>			<u>Maryland</u> <u>USA</u>		
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
<u>Michael Haron</u>			<u>Sarah Caslin</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. 17. INFORMANT & ADDRESS:		
<u>No</u>			<u>Unknown</u> <u>Records Spring Grove State Hospital</u>		

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVIEW WITH PERSONS KNOWING DECEASED ONSET AND DEATH	
443X IMMEDIATE CAUSE		(A) Cardiac failure		1 day	
ANTECEDENT CAUSE (B)		DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) Hypertensive c.v. disease		Years	
		DUE TO			
		(C) Uremia		1 week /	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Generalized arteriosclerosis				Years	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 5-1-1952, to 3-9-1955, that I last saw the deceased alive on 3-9-1955, and that death occurred at 10:30 AM, from the causes and on the date stated above. SIGNATURE S. Wachser M.D. Catonsville 28, Maryland 3-9-55 DATE SIGNED					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Burial		3-17-1955		CHARLES CEM Pikesville Md	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
		R. W. Hedrick		H. B. Walters	

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2329

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cockeysville  
 LENGTH OF STAY (in this place) 28 yrs.  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Powers Avenue

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Baltimore  
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cockeysville  
 STREET ADDRESS (If rural give location) Powers Avenue

## 3. NAME OF DECEASED:

(First) JAMES (Middle) CORNELIUS (Last) BARBOUR  
 (Type or Print)

## 4. DATE OF DEATH:

(Month) (Day) (Year)  
 March 10, 1955

## 5. SEX:

Male

## 6. COLOR OR RACE:

White

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Married

## 8. DATE OF BIRTH:

Sept. 29, 1925

## 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

79 yrs. Months Days Hours Min.

## 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:

Pharmacist

## 10b. KIND OF BUSINESS OR INDUSTRY:

Retail Druggist

## 11. BIRTHPLACE (State or foreign country):

Maryland

## 12. CITIZEN OF WHAT COUNTRY?

USA

## 13. FATHER'S NAME:

Lewis Coleman Barbour

## 14. MOTHER'S MAIDEN NAME:

Elizabeth Ann Ford

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No None

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

Family Records

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

452.2  
 Immediate cause

(a)

DUE TO

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between Onset And Death

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

## PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

## (CITY OR TOWN)

## (COUNTY)

## (STATE)

## TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at Work ☐

## HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 1948, to March 1955, that I last saw the deceased alive on March 9, 1955, and that death occurred at 1:30 P.M. from the causes and on the date stated above.

SIGNATURE  
 T. G. de Cadeo, M.D.

(Degree or title)

ADDRESS

DATE SIGNED

March 12/55

## 23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

## DATE THEREOF

Mar. 12, 1955

## NAME OF CEMETERY OR CREMATORY

Cockeysville

## LOCATION (City, town, or county)

Cockeysville, Maryland

## (State)

## DATE REC'D BY LOCAL REGISTRAR

14 March 1955

## REGISTRAR'S SIGNATURE

John Ernest MacRae

## 24. FUNERAL DIRECTOR

John Ernest MacRae

## ADDRESS

Towson, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 13 1955

BUREAU V. S.



2330

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fort Howard</u>	LENGTH OF STAY (in this place) <u>22 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> <u>34</u> <u>4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>1112 Ramblewood Road</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>HARRY E. BENSON</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>March 13, 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH <u>3-26-94</u>
9. AGE last birthday <u>60</u> yrs		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Merchant</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Tobacco Store</u>	
11. BIRTHPLACE (State or foreign country): <u>Baltimore Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William H. Benson</u>		14. MOTHER'S MAIDEN NAME: <u>Laura Thompson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Fort Howard, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>177X CARCINOMA OF PROSTATE WITH METASTASIS TO THORACIC 4TH VERTEBRA</u>		UNKNOWN	
ANTECEDENT CAUSE (B) <u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</u>			
(C) <u>DUE TO</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>3-8-55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Excision of Extradural Metastasis, Level T4</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 19, 19 55</u> to <u>March 13, 19 55</u> and that death occurred at <u>3:55 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>William B. Vandegrieff, M.D.</u>		ADDRESS <u>M. D. VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>3-14-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-17-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Louden Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>William J. Tiekner &amp; Sons, Inc.</u>	
		ADDRESS <u>North and Pennsylvania Ave., Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2331

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Wiltondale</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Wiltondale</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>600 Yarmouth Road</u>				STREET ADDRESS (If rural give location) <u>600 Yarmouth Road #1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Mrs. Carrie Holland Berger</u>				<u>March 11 1955</u>			
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Nov. 12, 1891</u>	9. AGE last birthday <u>63</u> yrs.	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Inspector Cles Envelope</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME: <u>Mr. Charles Holland</u>				14. MOTHER'S MAIDEN NAME: <u>Schmittke</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>21-24-1 21</u>		17. INFORMANT & ADDRESS: <u>Mr. Ernest Berger, 600 Yarmouth Road #4</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
442X IMMEDIATE CAUSE				(A) <u>Hypertensive Cardiovascular</u>			
ANTECEDENT CAUSE (S)				DUE TO <u>Renal Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <u>Chronic Trauma</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				(C) <u>3 mos</u>			
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 15, 1955</u> to <u>March 11, 1955</u> that I last saw the deceased alive on <u>March 10, 1955</u> , and that death occurred at <u>1047 M</u> , from the causes and on the date stated above.							
SIGNATURE <u>Albert C. Sikorsky</u>				ADDRESS <u>5939 Mc Elroy St</u>		DATE SIGNED	
M. D. <u>March 14, 1955</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THERE OF <u>March 14, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>MARCH 14 1955</u>		REGISTRAR'S SIGNATURE <u>John J. Ruck</u>		24. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck, 5305 Harford Road #14</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mr. Albert Sikorsky  
2939 Mc Elderry Street.  
Pr. 6 1034

2332

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Offices</u>		<u>26 yrs</u>		TOWN <u>Offices</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Int Zion</u>				STREET ADDRESS (If rural, give location) <u>Int Zion</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Georgia Bell Berryman</u>				<u>March 14 19 55</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH: (Month) (Day) (Year)	
				<u>Widowed</u>		<u>Sept 21, 1860</u>	
9. AGE last birthday: <u>94</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Fisher</u>				14. MOTHER'S MAIDEN NAME: <u>Don't know</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Mrs. Hubert Wiener, Offices, Inds</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
422.1 Immediate cause (a) <u>Chronic Myocarditis</u>							
Antecedent cause(s) (b) <u>Atherosclerotic Cardiovascular Disease</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>—</u>				19b. MAJOR FINDINGS OF OPERATION: <u>—</u>			
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF INJURY		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Jan 38</u> , 19 <u>58</u> , to <u>March 14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>March 5</u> , 19 <u>55</u> , and that death occurred at <u>10:30 P</u> .m., from the causes and on the date stated above.							
SIGNATURE <u>Joseph E. Bush</u>				(DEGREE OR TITLE) <u>MD</u>		DATE SIGNED <u>3/14/55</u>	
23. BURIAL, CREMATION, or other disposition (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Interment</u>		<u>March 17, 1955</u>		<u>Westbrook Methodist</u>		<u>Baltimore town Md</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3-16-55</u>		<u>Carol B. Elmer</u>		<u>Wm. Berryman &amp; Sons</u>		<u>Baltimore</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1944

1944

U. S. A.

1944



2333

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02307

## CERTIFICATE OF DEATH

Reg. Dist. No. 5

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>114</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>19 1200 Bridge Street Home</u>		STREET ADDRESS (If rural, give location) <u>1200 Bridge Street Home</u>	
3. NAME OF DECEASED (Type or Print) <u>William C. Carter</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>28</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov 13 - 1885</u>
9. AGE last birthday <u>69</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Chesapeake, Md</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Owner</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>W. C. Carter</u>		14. MOTHER'S MAIDEN NAME <u>W. C. Carter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>1-1-1-1-1-1-1-1-1-1</u>	
17. INFORMANT AND ADDRESS <u>William C. Carter, Jr., 1200 Bridge Street Home</u>			

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>6 hr.</u>
Immediate cause <u>Cerebral Hemorrhage</u>	(a) <u>Cerebral Arteriosclerosis</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last	(b) <u>Generalized arteriosclerosis</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arterioscl. C-V Dis. Parkinsonism</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct., 1954, to March 28 1955, that I last saw the deceased alive on March 8, 1955, and that death occurred at 1 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>March 31 - 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Frederick Cemetery</u>	LOCATION (City, town, or county) <u>Frederick, Md</u>	(State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>29-5-55</u>	REGISTRAR'S SIGNATURE <u>John H. Carter</u>	24. FUNERAL DIRECTOR <u>W. C. Carter</u>	ADDRESS <u>1200 Bridge Street Home</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

L.

2334

CERTIFICATE OF DEATH

Reg. Dist. No. 22

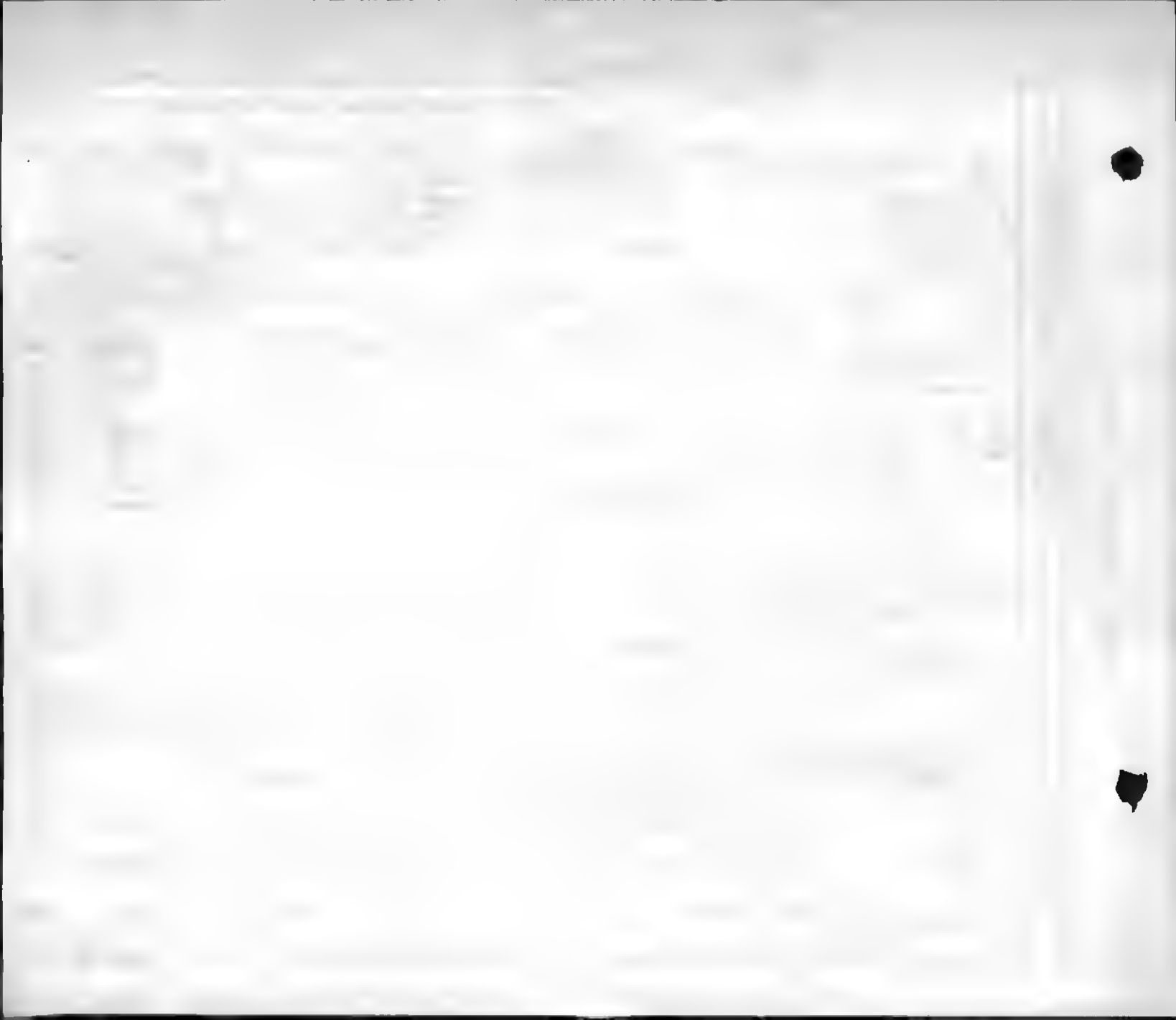
1. NAME OF DECEASED (Type or Print) <b>EVA MAY BLAKE</b>			2. DATE OF DEATH <b>MARCH 31 1955</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Baltimore County</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE COUNTY</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>X</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>RURAL BRIGHTEN, MD</b>		
C. Length of stay in Baltimore <b>54</b> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>6509 FAIRMOUNT AVE. BALT.</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>APRIL 22, 1904</b>		9. AGE (In years last birthday) <b>50</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>EDWARD WINK</b>			14. MOTHER'S MAIDEN NAME <b>ELLEN BROWN</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>VINCENT DE PAUL BLAKE</b> ADDRESS SAME		

18. <b>416X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <b>Rheumatic C. V. Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>About 35 yrs</b>
ANTECEDENT CAUSES				
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>about October 1951</b> to <b>March 31 1955</b> that (I) (we) last saw the deceased alive on <b>March 29 1955</b> , and that death occurred at <b>2:25 p. m.</b> , from the causes and on the date stated above.				
23A. SIGNATURE <b>Julius C. Bluck</b> M.D.		23B. ADDRESS <b>5356 Reisterstown Rd</b>		23C. DATE SIGNED <b>3/31/55</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-2-55</b>	24C. NAME OF CEMETERY OR CREMATORY <b>David Ridge</b>	24D. LOCATION (City, town, or county) (State) <b>P. Nesville Md</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>March 31 1955</b>		REGISTRAR'S SIGNATURE <b>Alfred H. Newell</b>		25. FUNERAL DIRECTOR <b>FRANK H. NEWELL</b> ADDRESS <b>Marysville Md</b>

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WRITE PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information should be fully supplied. Physicians: please write the causes of death clearly and legibly. This certificate must be filed in the BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER



## 2335 CERTIFICATE OF DEATH

Reg. Dist. No. 3.1

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>BALTIMORE</b>	MARYLAND	STATE <b>MARYLAND</b>	COUNTY <b>BALTO</b>
CITY (If outside corporate limits, write RURAL and give nearest town) <b>RURAL BALTIMORE</b>	LENGTH OF STAY (in this place) <b>6 YRS</b>	CITY (If outside corporate limits, write RURAL and give nearest town) <b>RURAL BALTIMORE</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>3521 TULSA RD BALTO 7 MD</b>		STREET ADDRESS (If rural give location) <b>3521 TULSA RD. BALTO. 7, MD</b>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <b>VICTORIA</b>	(Middle) <b>L.</b>	(Last) <b>BLUM</b>	(Month) <b>MARCH</b> (Day) <b>25</b> (Year) <b>19 55</b>
5. SEX: <b>F</b>	6. COLOR OR RACE: <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>MARRIED</b>	8. DATE OF BIRTH: <b>JAN 13, 1913</b>
9. AGE last birthday: <b>42</b> yrs.		10. MONTHS <b>4</b> DAYS <b>13</b> HOURS <b>13</b> MIN.	
11. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): <b>HOUSEWIFE</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME: <b>Jacob Kadbluski</b>		14. MOTHER'S MAIDEN NAME: <b>ALFRED CLAYTON BLUM</b>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>NO</b>		16. SOCIAL SECURITY No.: <b>3521 TULSA RD BALTO 7, MD</b>	
17. INFORMANT & ADDRESS: <b>ALFRED CLAYTON BLUM</b>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
(a) <b>GENERALIZED CARCINOMATOSIS</b>		<b>6 MOS.</b>	
Immediate cause DUE TO			
(b) <b>CARCINOMA OF OVARY</b>		<b>1 1/2 YRS</b>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO			
(c)			
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: <b>31 JAN 55</b>		19b. MAJOR FINDINGS OF OPERATION: <b>TUMOR MASS IN PELVIS WITH METASTASES THROUGHOUT ABDOMINAL CAVITY</b>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>MAR 24, 1955</b> , to <b>MAR 25 1955</b> , that I last saw the deceased alive on <b>MAR 24, 1955</b> , and that death occurred at <b>8:30 PM</b> , from the causes and on the date stated above.			
SIGNATURE (Degree or title) <b>B. Stanley Cohen, MD</b> ADDRESS <b>7306 Liberty Rd Balto 7, MD</b> DATE SIGNED <b>MAR 25 1955</b>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	
<b>Burial</b>		<b>3-29-55</b>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>New Cathedral Cemetery</b>		<b>Baltimore, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
<b>3-28-55</b>		<b>Ellsworth Armacost</b>	
REGISTRAR'S SIGNATURE		ADDRESS	
<b>R. F.</b>		<b>Ellsworth Armacost 4600 Liberty Heights Ave.</b>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2336

CERTIFICATE OF DEATH

Reg. Dist. No.

02340

1. NAME OF DECEASED (Type or Print) <b>JAMES S BLUMBERG</b>			2. DATE OF DEATH <b>3-28-55</b>		
3. PLACE OF DEATH: A. Baltimore <b>MD</b> , Maryland <b>Baltimore County</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>MD</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>X</b> <b>2701 Gwynmore Ave</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>3401-4</b>		
C. Length of stay in Baltimore <b>00</b> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>3711 Liberty Heights Ave</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>12-18-1899</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <b>Loch Haven Pa</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Isaac Blumberg</b>			14. MOTHER'S MAIDEN NAME <b>Mary Fleishman</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Lester H Blumberg</b>			ADDRESS		

16. **260X**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

**Acute Myocardial Infarction**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

**Coronary Atherosclerosis**  
**Diabetes Mellitus**

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II	19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	

22. I certify that (I) (this hospital) attended the deceased from **Feb 15** to **March 28**, 19**55**, that (I) (we) last saw the deceased alive on **March 27**, 19**55**, and that death occurred at **11 A** m., from the causes and on the date stated above.

23A. SIGNATURE <b>Albert Rubinstein</b> M.D.	23B. ADDRESS <b>5415 Park Heights Ave</b>	23C. DATE SIGNED <b>March 29, 1955</b>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3-29-55</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Beth T Filoh</b>	24D. LOCATION (City, town, or county) (State) <b>Balto MD</b>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <b>Jack Lewis</b>	25. FUNERAL DIRECTOR <b>7100 Eutaw Rd</b>	ADDRESS

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

THE NEW YORK PUBLIC LIBRARY

ASTOR  
LENOX  
TILDEN

2337

## CERTIFICATE OF DEATH

Reg. Dist. No.

32

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
X CITY (If outside corporate limits, write OR and give nearest town) <u>Pikesville</u>		LENGTH OF STAY (in this place) <u>21 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Nelson Rd</u>				STREET ADDRESS (If rural give location) <u>Nelson Rd</u>		1	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>William Edgar Bodensick</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>March 29 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>24 Jan 1894</u>	
				9. AGE last birthday <u>61</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Product</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Product</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME: <u>William Bodensick</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Bottenbacher</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>214-24-0097</u>		17. INFORMANT & ADDRESS: <u>Mrs William Bodensick</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Chronic myelogenous leukemia</u>						10 yrs	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1 Dec., 1949</u> to <u>29 Mar., 1955</u> , that I last saw the deceased alive on <u>29 Mar., 1955</u> , and that death occurred at <u>730 P. M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paul H. Rouse</u>		ADDRESS <u>Pikesville 8 md</u>		DATE SIGNED <u>29 Mar 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>APR 11, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>DR. D. Ridge</u>		LOCATION (City, town, or county) (State) <u>Pikesville Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>March 30, 1955</u>		REGISTRAR'S SIGNATURE <u>Karoly A. Jewell</u>		24. FUNERAL DIRECTOR <u>Frank H. Jewell</u>		ADDRESS <u>Pikesville Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5. 11. 1962

10. 11. 1962

2312 MARYLAND STATE DEPARTMENT OF HEALTH

02312

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk - 22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1827 East Avenue - 22</u>		STREET ADDRESS <u>7115 Holabird Avenue</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>CHARLES</u> <u>KARL</u> <u>BORMAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 2</u> <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>April 20, 1885</u>
9. AGE last birthday <u>69</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Poland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>live moulder</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Borman</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>(If year, give war or dates of service)</u>	
17. INFORMANT AND ADDRESS <u>Mrs. John Michlich - 1827 East Ave</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>arteriosclerotic Heart Disease</u>		<u>6 mo.</u>
Antecedent cause(s) (b) <u>Chronic nephritis</u>		<u>6 mo.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?

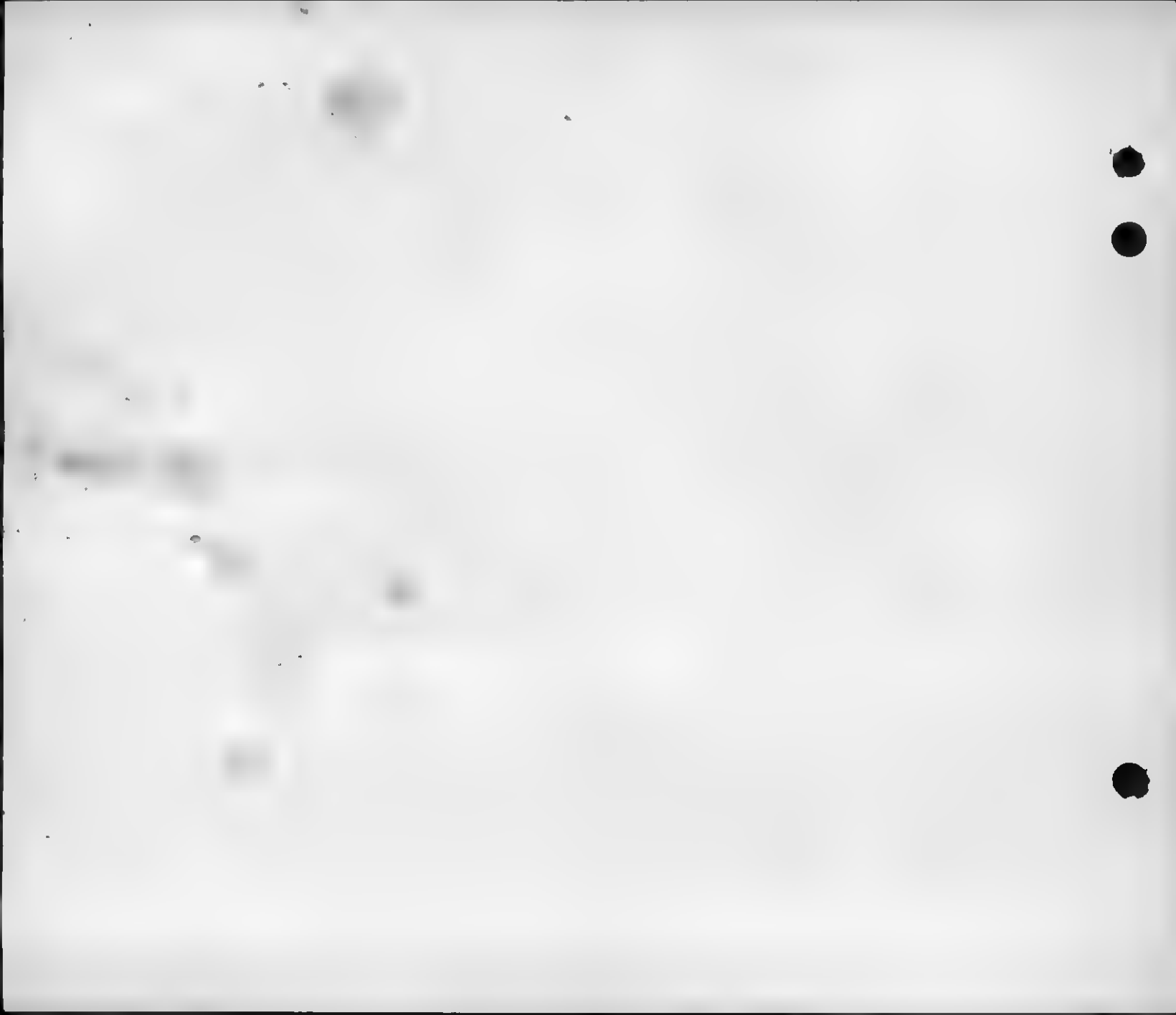
22. I hereby certify that I attended the deceased from Sept, 1954, to Mar 2, 1955, that I last saw the deceased  
alive on March 2, 1955, and that death occurred at 4:50 p. m., from the causes and on the date stated above.

SIGNATURE <u>Eugene F. Nevy</u>	(Degree or title)	ADDRESS <u>M.D. 7001 Mornington Rd Dundalk, Md</u>	DATE SIGNED
23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>March 6 1955</u>	NAME OF CEMETERY OR CREMATORY <u>1st United Evangelical</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
DATE REC'D BY LOCAL REG. <u>3-7-55</u>	REGISTRAR'S SIGNATURE <u>au bed</u>	24. FUNERAL DIRECTOR <u>H. SANDER &amp; SONS, INC.</u>	ADDRESS <u>Balto., Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH. COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 TOWN Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hosp</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson, Maryland</u> STREET ADDRESS (If rural give location) <u>9 Linden Terrace</u>	
3. NAME OF DECEASED (Type or Print) <u>May</u> (First) <u>MMI</u> (Middle) <u>BRANCAMP</u> (Last)		4. DATE (Month) (Day) (Year) OF DEATH <u>March 27</u> 19 <u>55</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH. <u>9-17-1866</u>
9. AGE last birthday <u>88</u> yrs		10. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Henry L. Bowen</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Parks Bowen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT'S ADDRESS <u>Mrs. Henry L. Parlette Falls Road, Upperco, Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
334X IMMEDIATE CAUSE (A) <u>Respiratory failure</u> DUE TO			
ANTECEDENT CAUSE (B) <u>Cerebral arteriosclerosis</u> DUE TO			
(C) <u>Generalized Arteriosclerotic vascular disease</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diarrhea of unknown cause; pyuria</u> <u>diarrhea</u> <u>and azotemia of undetermined cause</u> <u>4 hrs prior</u>			
19A. DATE OF OPERATION <u>none</u>		19B. MAJOR FINDINGS OF OPERATION <u>to death</u>	
20A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
20C. WHERE DID (City or town) (County) (State)		20D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
20E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 31, 1955 to March 27, 1955 that I last saw the deceased alive on March 27, 1955, and that death occurred at 1 A.M. from the causes and on the date stated above.			
SIGNATURE <u>Lindsey D. Campbell</u>		ADDRESS <u>M. D. Spring Grove State Hosp. 1-27-55</u>	
23. BURIAL CREMATION, DATE THEREOF <u>Mar 29, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cem.</u>	
LOCATION (City, town, or county) (State) <u>Towson, Md.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>3-27-55</u>		REGISTRAR'S SIGNATURE <u>E. W. H. H. H. H.</u>	
FUNERAL DIRECTOR <u>John Burns &amp; Sons, Towson, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





2339

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Essex  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 609 Maryland Ave.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Balto.  
 CITY (If outside corporate limits, write RURAL and give nearest town) Essex  
 STREET ADDRESS (If rural, give location) 609 Maryland Ave.

## 3. NAME OF DECEASED:

(First) Lena (Middle) Brashears (Last) Brashears

4. DATE OF DEATH: (Month) (Day) (Year)  
March 7 - 19 55

## 5. SEX:

Female

## 6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

## 8. DATE OF BIRTH:

June 8 - 1874

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.  
80 yrs. 9 Months 9 Days 9 Hours 9 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

William Mueller

## 14. MOTHER'S MAIDEN NAME:

Margareta Schreiner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

Edward Brashears 609 Maryland Ave.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

442X  
 Immediate cause

DUE TO

(a) Arterio-sclerotic Hypertensive Cardio-Vascular

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO

(b) Renal Disease

(c)

INTERVAL BETWEEN ONSET AND DEATH

6 years

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

no

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☒ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/1/49 19....., to March 7, 1955....., that I last saw the deceased alive on March 7, 1955....., and that death occurred at 3:30 P.....m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

3-8-55

R W

Hadco

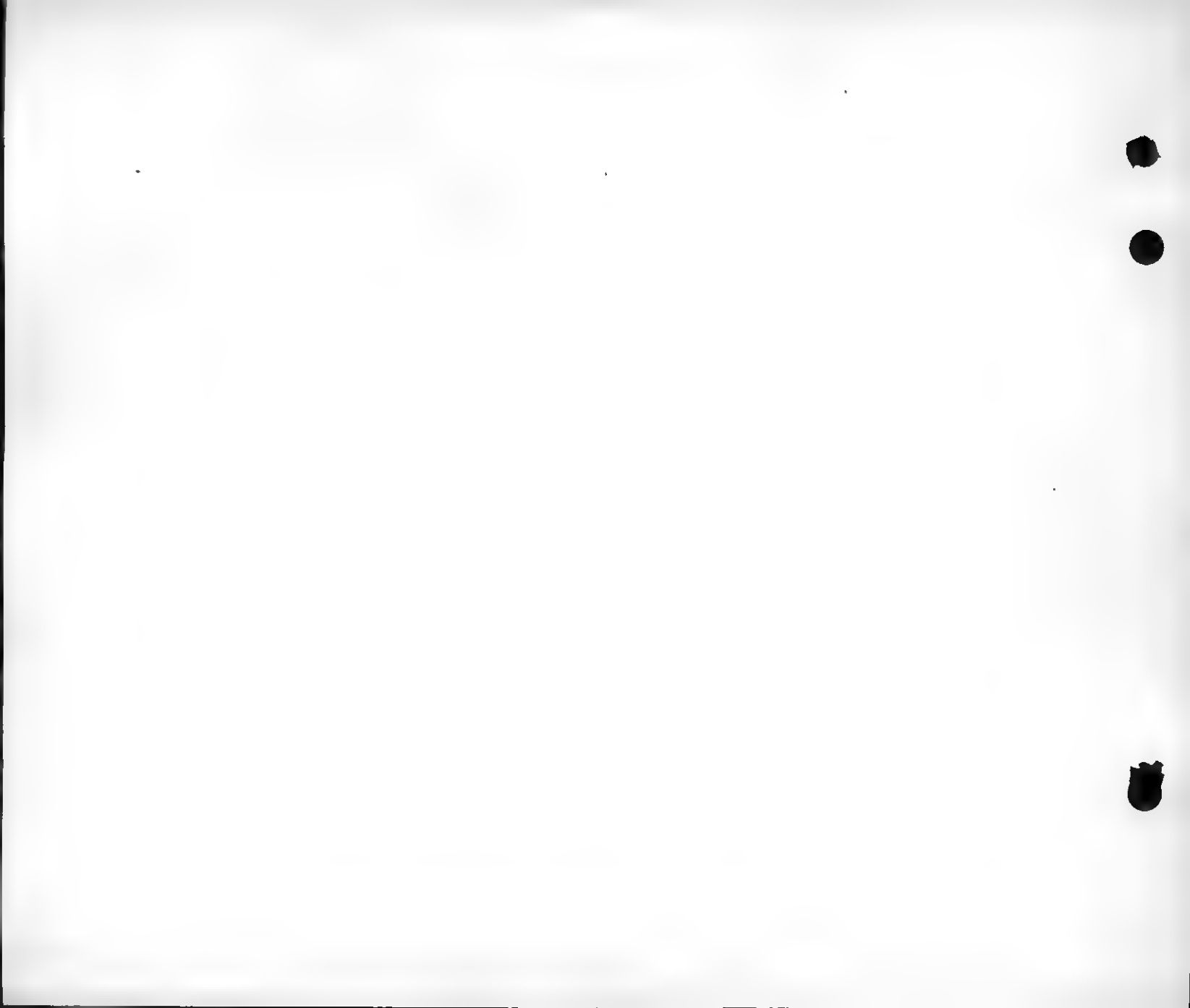
Am S. Donnelly

Essex, Md.

Essex, Md.

Essex, Md.

MARGIN RESERVED FOR BINDING



2340

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town) Woodtown  
 OR TOWN 4 mos.  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 2009 Thayers Terrace

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Balto.  
 CITY (If outside corporate limits, write RURAL and give nearest town) Rural - Parkton  
 OR TOWN 1  
 STREET ADDRESS (If rural give location) Prettyboy Dam Rd.

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

DanielR.Bruehl

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

March 81955

## 5. SEX:

## 6. COLOR OR RACE:

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Sp.)

## 8. DATE OF BIRTH:

## 9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MaleWhiteWidowedSept. 10, 186589 yrs.MonthsDays

## 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired.

## 10b. KIND OF BUSINESS OR INDUSTRY.

## 11. BIRTHPLACE (State or foreign country):

## 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0  
Immediate cause(a) Cardio vascular disease

DUE TO

## Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Arterio sclerosis

DUE TO

(c)

Interval Between Onset And Death  
about  
2 yr.

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

## PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

## (CITY OR TOWN)

## (COUNTY)

## (STATE)

## TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

## HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from Feb. 19 55 to Marc. 8, 19 55, that I last saw the deceased alive on Mar. 7, 19 55 and that death occurred at 7:45 AM, from the causes and on the date stated above.  
 SIGNATURE John Stubbitt (Degree or title) ADDRESS 2220 Garrison Blvd. DATE SIGNED 3/8/55

## 23. BURIAL, CREMATION, REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

## (State)

## DATE RECD BY LOCAL REGISTRAR

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

5-8-55Aug. 1955St. Carmel CemeteryParkton, Balto. Co. Md.Jacob H. HunsickerNew Freedom, Pa.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5 2 100

01 10

2341

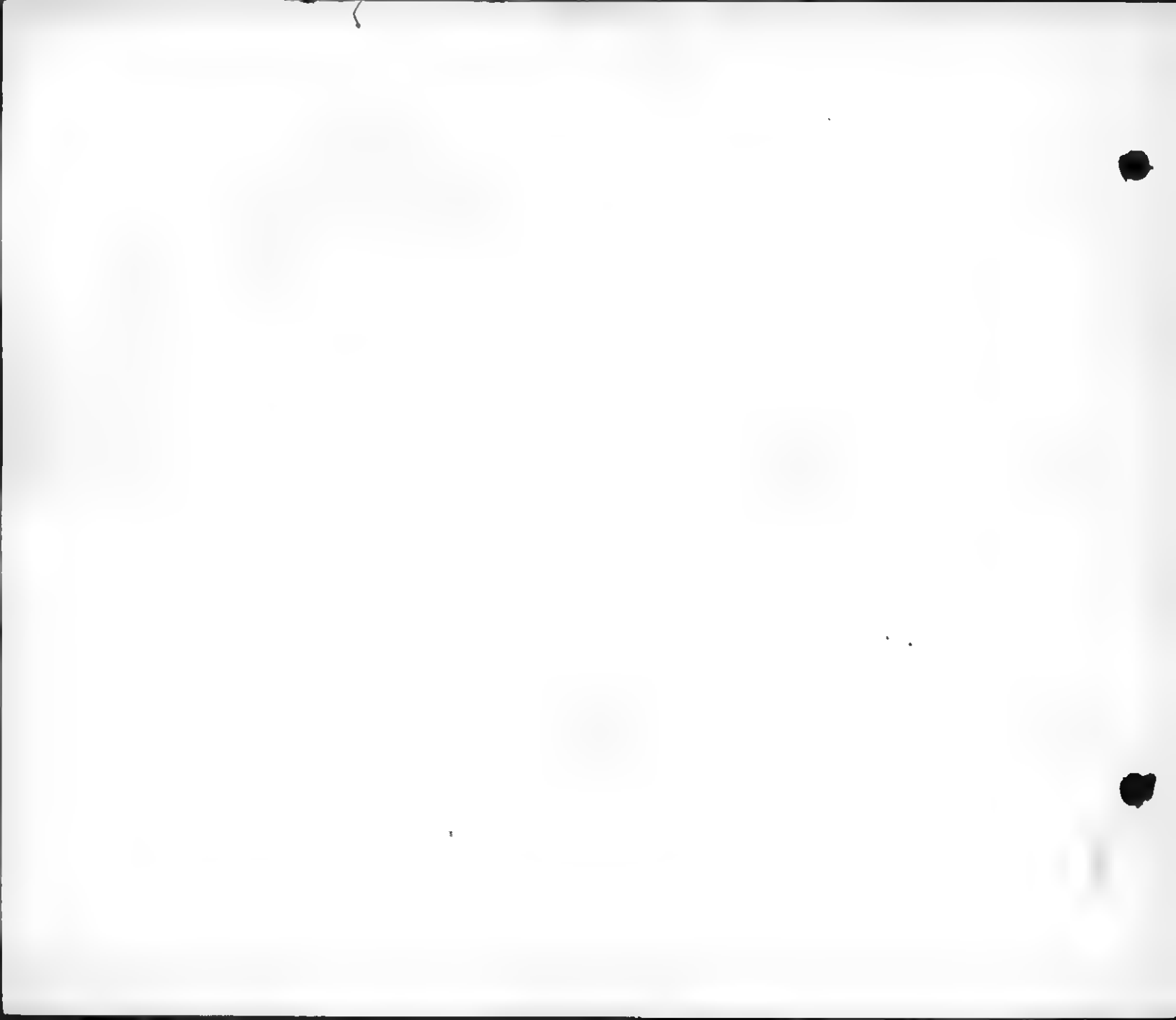
## CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>BALTO.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>RURAL - WOODLAWN</u>		<u>73 YRS.</u>		TOWN <u>RURAL - WOODLAWN</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1919 GWYNN OAK AVE.</u>				STREET ADDRESS (If rural give location) <u>1919 GWYNN OAK AVE.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: <u>RHODA</u> <u>LOUISE</u> <u>BUCKHEIT</u>				DATE OF DEATH: <u>3</u> <u>30</u> <u>1955</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>N</u>		7. SINGLE MARRIED WIDOWED DIVORCED <u>WIDOWED</u>		8. DATE OF BIRTH <u>3/26/82</u>	
9. AGE last birthday <u>73</u> yrs		10. MONTHS <u>73</u>		11. DAYS <u>73</u>		12. HOURS <u>73</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEWORK</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>HOUSEWORK</u>		11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>WILLIAM COMPTON</u>				14. MOTHER'S MAIDEN NAME: <u>KATHERINE SHANNESY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NUMBER <u>220-93352</u>			
17. INFORMANT & ADDRESS: <u>NONE NUMBER DAUGHTER - MILDRED FONTE</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CEREBRAL APOPLEXY</u>						2 WEEKS.	
ANTECEDENT CAUSE (B) <u>DIABETES MELLITUS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>HYPERTENSIVE CARDIOVASCULAR DISEASE.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/5</u> , 19 <u>55</u> , to <u>3/30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/29</u> , 19 <u>55</u> , and that death occurred at <u>8:20</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>Edwin G. Strong</u>		ADDRESS <u>8204 LIBERTY RD., BALTO 7, Md.</u>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-2-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		LOCATION (City, town, or county) <u>Woodlawn Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-30-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR ADDRESS <u>G. Howard Strong 3207 W. NORTH AVE.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please, write the causes of death clearly and legibly.



2342

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND <input checked="" type="checkbox"/>	STATE <u>Md.</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cockeysville</u>	LENGTH OF STAY (in this place) <u>7 yrs-7m.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	<u>34-1-4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Masonia Home, Cockeysville</u>		STREET ADDRESS (If rural give location)	<u>2336 Edmondson Ave</u>
3. NAME OF DECEASED: (Type or Print) <u>Virginia</u>	(First) (Middle) (Last) <u>Buckley</u>	4. DATE (Month) (Day) (Year) OF DEATH <u>March 14 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Oct. 3rd, 1876</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>	9. AGE last birthday: IF UNDER 1 YEAR: <u>78</u> yrs. <u>5</u> m. <u>5</u> d.
11. BIRTHPLACE (State or foreign country): <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY: <u>Bald, Co.</u>	
13. FATHER'S NAME: <u>Rudolph Mateling</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Dorr</u>	
15. WAS DECEASED EVER IN U.S. ARMY OR FORCE? (Yes, no, or unk.): <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS: <u>Laura M. Schroeder</u>			

15. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
4221	(A) <u>Arterio-sclerotic Cardiovascular disease</u>	<u>over 7 yrs</u>
IMMEDIATE CAUSE (A) DUE TO		
ANTECEDENT CAUSE (B) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebral Vascular accident</u>		<u>about 1 1/2 yrs</u>
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1947 to Mar 14 1955 that I last saw the deceased alive on Mar 13, 1955, and that death occurred at 7:30 A.M. from the causes and on the date stated above.

SIGNATURE Walter J. Kuo M. D. ADDRESS Cockeysville Md DATE SIGNED 3/14/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	<u>3/16/55</u>	<u>Louder Pk</u>	<u>Baltimore Md</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>3/16/55</u>	<u>Laura M. Schroeder</u>	<u>M. M. Cook</u>	<u>St Paul &amp; Preston St</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

EDWARD A. S.



## CERTIFICATE OF DEATH

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

VS. A15

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2313

## CERTIFICATE OF DEATH

Reg. Dist. No. 111

## 1. PLACE OF DEATH:

COUNTY BaltimoreCITY (If outside corporate limits, write RURAL OR and give nearest town) DundalkHOSPITAL OR INSTITUTION OR STREET ADDRESS 2980 Cornwall Road

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTYCITY (If outside corporate limits, write RURAL and give nearest town) BaltimoreSTREET ADDRESS (If rural give location) 3006 White Ave.

## 3. NAME OF DECEASED:

(First)

JENNIL

(Middle)

V.

(Last)

BUSCH

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

March 16,19 55

## 5. SEX:

Female

## 6. COLOR OR RACE:

White7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

## 8. DATE OF BIRTH:

Sept. 1, 1874

## 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS

80 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): At home

## 10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland12. CITIZEN OF WHAT COUNTRY? U.S.A.

## 13. FATHER'S NAME:

George Jones

## 14. MOTHER'S MAIDEN NAME:

Don't know

## 15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No.

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

Mrs. J. Stephenson 2980 Cornwall Road

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

592X  
Immediate cause(a) Arterio-Sclerosis heart disease  
DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Chronic nephritis  
DUE TO

(c)

Interval Between Onset And Death

1 yr10 yrs

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-12, 1955, to 3-16, 1955, that I last saw the deceased alive on 3-15, 1955 and that death occurred at 14 Noon, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

March 19, 1955Loudon Park CemeteryBaltimore, Md.

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

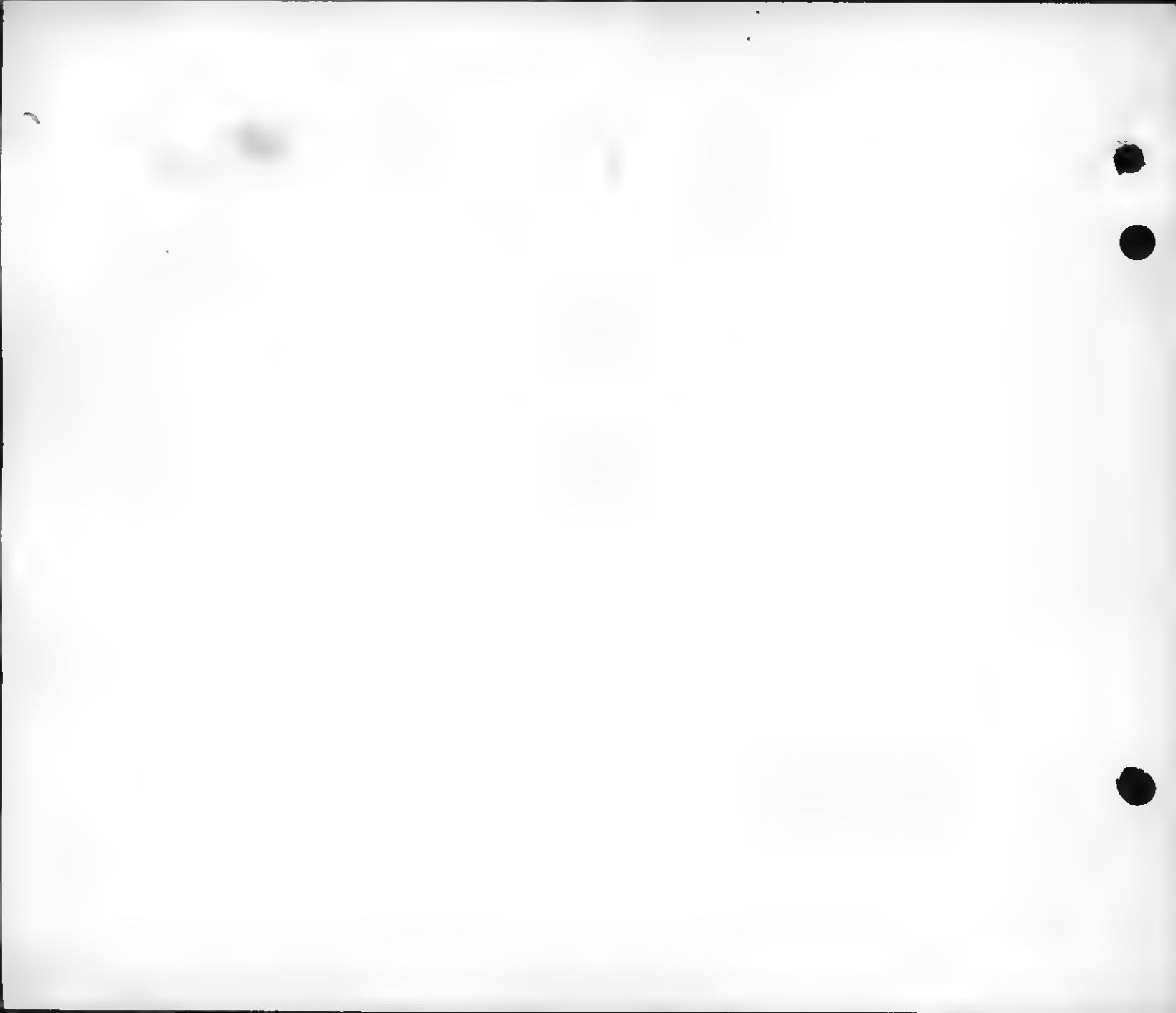
## 24. FUNERAL DIRECTOR

ADDRESS

Ullrich Funeral Home 2112 Dundalk Ave. 22

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2344

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02321

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

1. PLACE OF DEATH COUNTY <u>Hyde Park Md</u> <u>Balts. Co.</u> CITY (if outside corporate limits, write RURAL and give nearest town) <u>Hyde Park</u> TOWN <u>Hyde Park</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Balts</u> CITY (if outside corporate limits, write RURAL and give nearest town) <u>Balto</u> TOWN <u>Balto</u> STREET ADDRESS (If rural, give location) <u>Hyde Park Md</u>	
3. NAME OF DECEASED (First) <u>James</u> (Middle) <u>Lealdwell</u> (Last) <u>—</u>		4. DATE OF DEATH (Month) <u>Mar</u> (Day) <u>17</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 24<sup>th</sup> 1914</u> <u>41</u> <u>40</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Route Manager Archers Laundry</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
13. FATHER'S NAME <u>Wm Lealdwell</u>		14. MOTHER'S MAIDEN NAME <u>—</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT (NAME AND ADDRESS) <u>Lillian Lealdwell Hyde Park Md</u>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>12 phylia</u>		<u>1 hr.</u>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		<u>7 mos.</u>
(c) <u>Carcinoma of pharynx with metastases</u>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE TIME (Month) (Day) (Year) (Hour) OF INJURY	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	(CITY OR TOWN) (COUNTY) (STATE)
HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from <u>3/12</u> , 19 <u>55</u> , to <u>3/17</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/15</u> , 19 <u>55</u> , and that death occurred at <u>4:00</u> p.m., from the causes and on the date stated above.			
SIGNATURE <u>J. H. Lealdwell</u>		ADDRESS <u>404 Eastern Ave East, Md.</u>	
DATE SIGNED <u>3/17/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Mar 21<sup>st</sup> 1955</u>	<u>Oak Lawn</u>	<u>Eastern Ave Rd</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>3-18-55</u>	<u>J. H. Lealdwell</u>	<u>Geo. E. Cook</u>	<u>1701-23rd Patterson Park Ave</u>





U. S. AIR FORCE

1AR



2346

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. ... 38

**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE	
BALTIMORE		MARYLAND	
CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3117 E Joppa Rd		3117 E Joppa Rd	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
Katherine E		MARCH 13 1955	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
F	W	WIDOWED	8-2-1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
SECRETARY		CAN Co.	MARYLAND
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Thomas CARNEY		Mary McDERMOTT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
No		212-01-6795	Cecelia CARNEY 3117 E Joppa Rd
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
4-2-2 Immediate cause (a)..... Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c).....			Heart's 'tokes' syn. arr. myocardial infarct. Congestive failure
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Jan. 1953, to March 1955, that I last saw the deceased alive on Mar 1, 1955, and that death occurred at 6:30 p.m., from the causes and on the date stated above.		SIGNATURE (Degree or title) ADDRESS DATE SIGNED	
Mabel C. Gray		1315 55	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	3/16/55	PARKWOOD	BALTO. MD
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Mar 15, 1955	Mabel C. Gray	CHAS F EVANS & Son	8802 HARTFORD RD

BUREAU V. S.

MAR 13 7

RECEIVED

2347

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town OR TOWN <u>Halethorpe</u>	
TOWN <u>Catonsville</u>		STREET ADDRESS (If rural give location) <u>1824 Park Ave.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in the Pines 16 Fusting Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>LOTTIE PACE CAROTHERS</u>		OF DEATH: <u>Mar. 8, 1955</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>July 24, 1877</u>
9. AGE last birthday: <u>77</u> yrs.		10. MONTHS: <u>77</u>	11. DAYS: <u>77</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>--</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>	
11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>--</u>	
13. FATHER'S NAME: <u>John R. Pace</u>		14. MOTHER'S MAIDEN NAME: <u>Sallie Hagerman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>--</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>--</u>	
17. INFORMANT & ADDRESS: <u>Halethorpe, Md. Mr. Joseph H. Carothers - 1824 Park Ave.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Hypertensive A.S.C. V.D.</u>		
ANTECEDENT CAUSE (B) <u>terminal congestive failure</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>2/4, 1954</u> to <u>3/8, 1955</u> that I last saw the deceased alive on <u>3/7, 1955</u> , and that death occurred at <u>439 P.M.</u> from the causes and on the date stated above.				
SIGNATURE <u>[Signature]</u>		M.D. <u>[Signature]</u>		DATE SIGNED <u>3/9/55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>3/10/55</u>		NAME OF CEMETERY OR CREMATORY <u>Greenhill Cem.</u>
LOCATION (City, town, or county) (State) <u>Danville, Va.</u>		DATE REC'D BY LOCAL REGISTRAR <u>3-9-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>
FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>[Signature]</u>		

MARGIN RESERVED FOR BINDING

VS. A11-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 11 1955



2348

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Balt</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Pikesville</u>		<u>32 yrs</u>		TOWN <u>Pikesville</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Smith Ave</u>				STREET ADDRESS (If rural give location) <u>Smith Ave</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
CAROLINE MAY Carter				OF DEATH: <u>March 31 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>married</u>		8. DATE OF BIRTH: <u>14 May 1890</u>	
9. AGE last birthday <u>64</u> yrs		10. KIND OF BUSINESS OR INDUSTRY: <u>housewife</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William Gaigler</u>				14. MOTHER'S MARDEN NAME: <u>Mary Bothoff</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no.</u>				16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT & ADDRESS: <u>Mr Wilson H Carter, seven mi Lane Pikesville</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Cerebral vascular accident</u>						4 days	
ANTECEDENT CAUSE (B) <u>Hypertension</u>						3 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>18 Oct.</u> , 195 <u>4</u> , to <u>31 Mar</u> , 195 <u>5</u> , that I last saw the deceased alive on <u>30 Mar.</u> , 195 <u>5</u> , and that death occurred at <u>2:30</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>Paul &amp; Rayne</u>		ADDRESS <u>Pikesville 8th</u>		DATE SIGNED <u>31 Mar 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/2/55</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4</u>		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR <u>Sam J. Pickens &amp; Sons - Balt</u>		ADDRESS <u>md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02326

2349

## CERTIFICATE OF DEATH

Reg. Dist. No.

35

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
55 TOWN <u>Towson</u>				TOWN <u>Towson</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>505 W. Joppa Rd.</u>				STREET ADDRESS (If rural give location) <u>505 W. Joppa Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
JUDSON E. CLARKE				OF DEATH: <u>Mar.</u> <u>21</u> , <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday yrs.	10. UNDER 1 YEAR Months	11. UNDER 24 HRS. Days	12. UNDER 24 HRS. Hours Min.
male	white	married	Dec. 24, 1899	55			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Commercial Agt. - Telephone Co.</u>						<u>Maryland</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Wm. J. Clarke</u>				<u>Mary Mackenzie</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				17. INFORMANT & ADDRESS:			
no				<u>Mrs. Leona E. Clarke-505 W. Joppa Rd.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X							
IMMEDIATE CAUSE (A) <u>HEMORRHAGE, Cerebral arterial</u>							
DUE TO							
ANTECEDENT CAUSE (B) <u>HYPERTENSION, Arterial</u>							
DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>—</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>							
19A. DATE OF OPERATION: <u>none</u> 19B. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
						INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 14</u> , 19 <u>55</u> , to <u>March 21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Jan 14</u> , 19 <u>55</u> , and that death occurred at <u>3:15</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>A.S. Charney</u>				ADDRESS <u>M.D. 6710 Yorkly</u>		DATE SIGNED <u>March 22 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/23/55</u>		<u>Loudon Park Cem.</u>		<u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3/24/55</u>		<u>A.W. Hedrick</u>		<u>Wm. J. Pickner &amp; Sons</u>		<u>Balto. Md.</u>	





PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

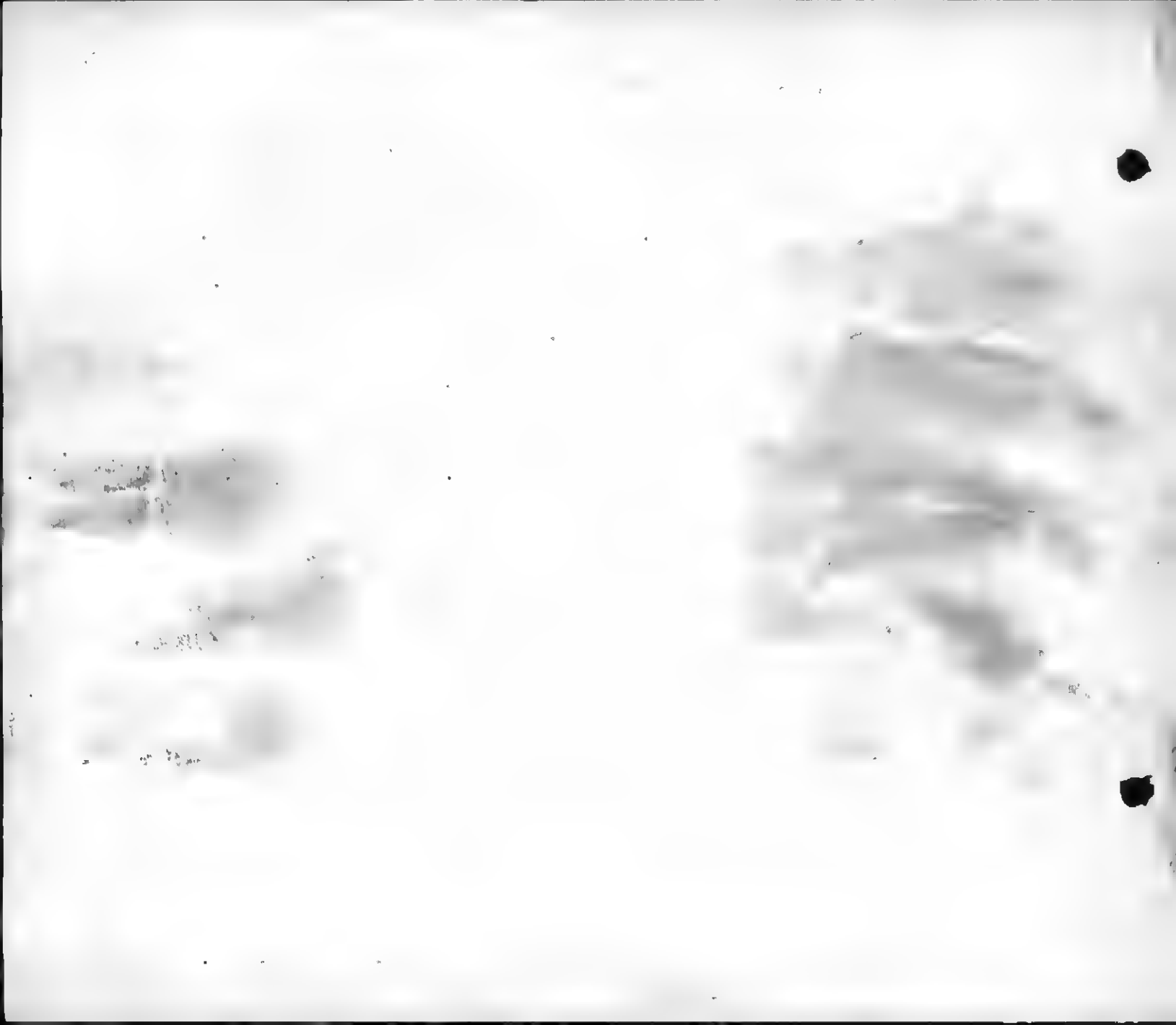
02327

2350

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <u>Rogers Forge</u>				TOWN <u>Rogers Forge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>211 S. Tyrone Rd.</u>				STREET ADDRESS (If rural give location) <u>211 S. Tyrone Rd.</u>			
3. NAME OF DECEASED: (First) <u>NELLYE</u> (Middle) <u>T.</u> (Last) <u>COLE</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Mar.</u> <u>15</u> , 19 <u>55</u>			
5. SEX	6. COLOR OR RACE:	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>female</u>	<u>white</u>	<u>widowed</u>	<u>Apr. 15, 1867</u>	<u>87</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>		11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: <u>Nichols Tillman</u>				14. MOTHER'S MAIDEN NAME: <u>Matilda Storck</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Balto. 10 Mr. Edwin T. Cole, Jr. - Tidgemede Apts.</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute Cardiac Failure</u>							
ANTECEDENT CAUSE (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 1, 1955</u> , to <u>March 16, 1955</u> , that I last saw the deceased alive on <u>3/16</u> , 19 <u>55</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Lawrence C. Rock M.D.</u>		ADDRESS <u>6805 York Rd. Baltimore 12</u>		DATE SIGNED <u>3/17/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		LOCATION (City, <u>Balto., Md.</u> or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>3-18-55</u>		REGISTRAR'S SIGNATURE <u>Dr. H. H. H. H.</u>		FUNERAL DIRECTOR'S SIGNATURE <u>John J. Trehaner &amp; Sons</u>		ADDRESS <u>Balto. Md.</u>	



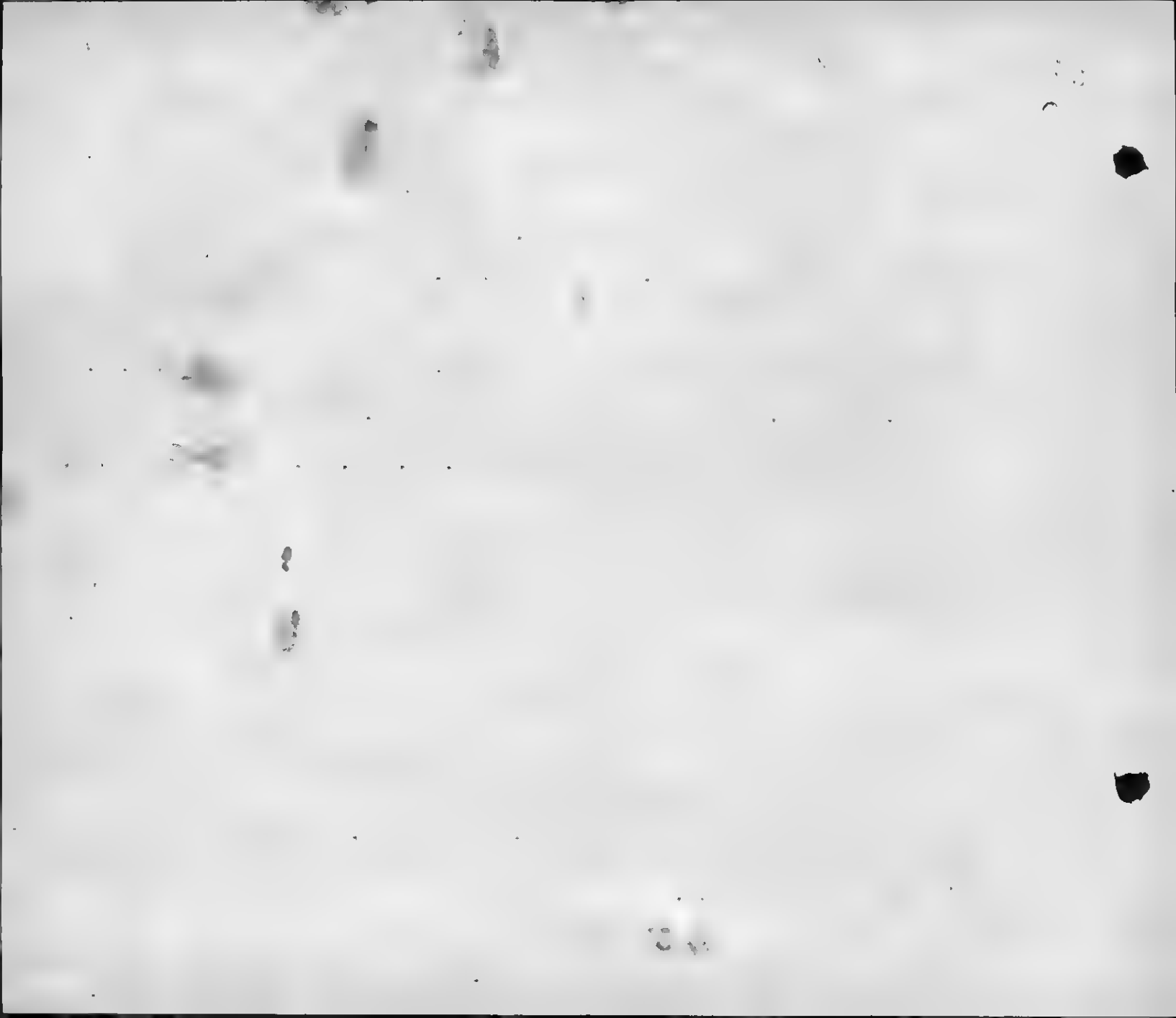
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 102328

## 2351 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Baltimore</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Fort Howard</b>	LENGTH OF STAY (in this place) <b>6 Days</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Veterans Administration Hosp.</b>		STREET ADDRESS (If rural give location) <b>5013 Reisterstown, Road</b>	
3. NAME OF DECEASED: (First) (Middle) (Last) <b>OLIVER C. CONN, JR.</b>		4. DATE (Month) (Day) (Year) OF DEATH <b>March 10 1955</b>	
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH: <b>May 26, 1925</b>
9. AGE last birthday: <b>29</b>		10. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Estimator, Roofing Company</b>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <b>Essex, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME: <b>OLIVER C. CONN, SR.</b>		14. MOTHER'S MAIDEN NAME: <b>LILLIAN MN. SCHMIDT</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or ynk.) (If Yes, give war or dates of service) <b>Yes WW-II</b>		16. SOCIAL SECURITY NO. <b>212-20-7718</b>	
17. INFORMANT & ADDRESS: <b>Clin. Rec., Vet. Adm. Hosp. Fort Howard, Md.</b>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
592X IMMEDIATE CAUSE (A) <b>CHRONIC NEPHRITIS</b>		UNKNOWN	
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>VA M.</b>	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Mar. 4, 1955</b> , to <b>Mar. 10, 1955</b> , and that death occurred at <b>5:45 P.M.</b> , from the causes and on the date stated above.			
SIGNATURE OF PHYSICIAN <b>WILLIAM B. VANDEGRIFT, M.D.</b>		DATE SIGNED <b>M.D. VAH, FORT HOWARD, MARYLAND 3-11-55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	DATE THEREOF <b>MAR. 14, 1955</b>	NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore, Maryland</b>	
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <i>[Signature]</i>	24. FUNERAL DIRECTOR <b>Wm. Cook-Blight Funeral Home</b>	
		ADDRESS <b>6009 Harford Road, Baltimore 14, Md.</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02329  
2352 CERTIFICATE OF DEATH

Reg. Dist. No. ....

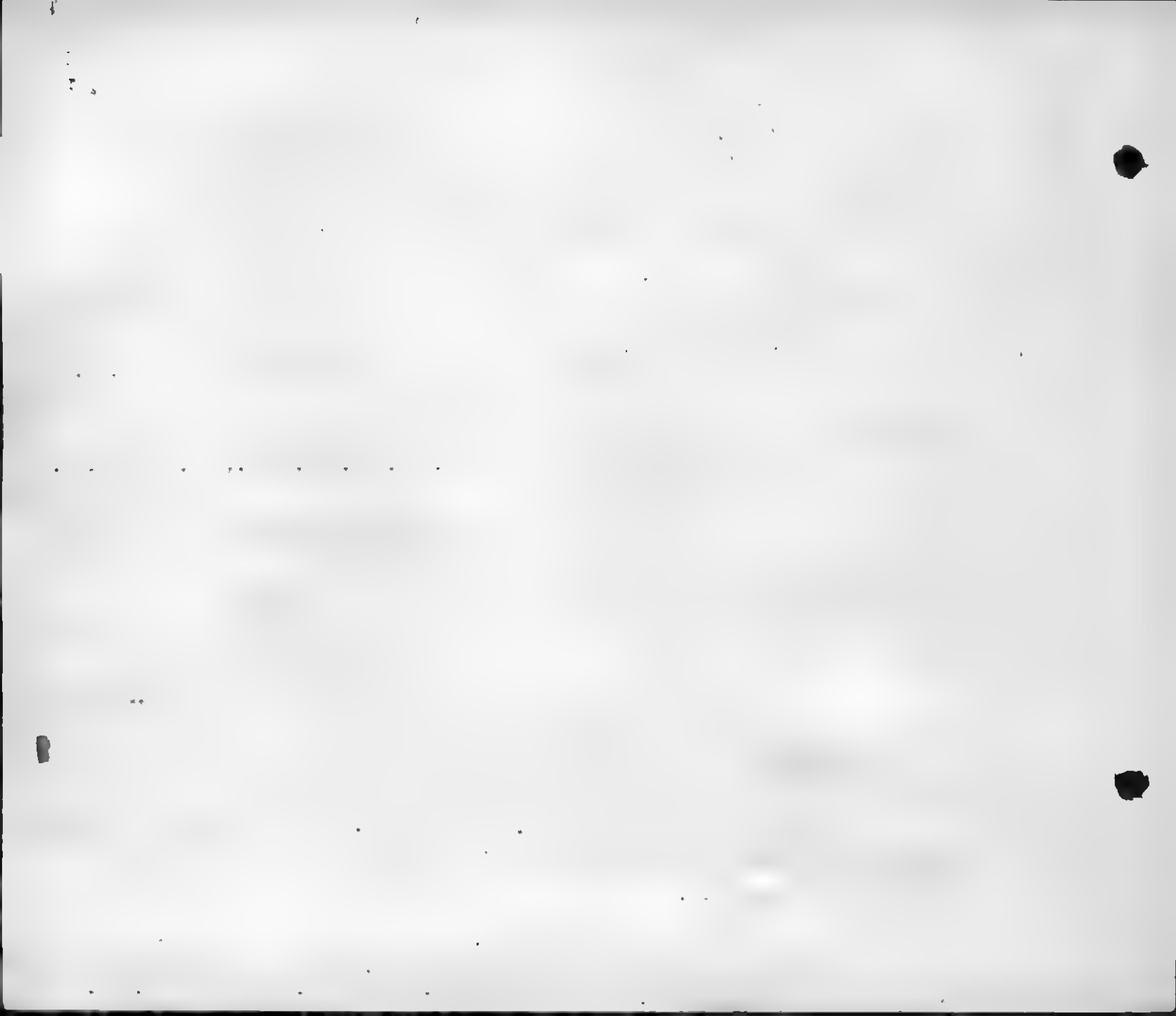
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>51 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mardela Springs</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>Route 1, Box 72</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ELISHA M. COOK</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>March 10 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>2/13/21</u>	9. AGE last birthday <u>34</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Culler</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Oyster House</u>		11. BIRTHPLACE (State or foreign country): <u>Mardela Springs, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>John Cook</u>				14. MOTHER'S MAIDEN NAME: <u>Daisy Waller</u>			
15. Was DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) <u>WW II Unknown</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>20 X</u>							
(A) SOFTENING AND DISCOLORATION OF LENTICULAR NUCLEI OF BRAIN						UNKNOWN	
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						UNKNOWN	
(B) DIABETES MELLITUS							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>3-9-55</u>		19B. MAJOR FINDINGS OF OPERATION <u>Exploratory Laporatomy for paralytic ileus- duration 1 wk</u>					
21A. ACCIDENT WAS UNDERLYNG OR CONTRIBUTING CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21B. PLACE (Home, farm, factory, street, office bldg., etc.) <u>VA</u>		21C. WHERE DID INJURY OCCUR? <u>VA</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>VA</u>			
22. I hereby certify that I attended the deceased from Jan. 18, 1955, to Mar. 10, 1955, and that death occurred at 9:20 M, from the causes and on the date stated above.							
SIGNATURE <u>WILLIAM B. VANDEGRIFF, M.D.</u>		ADDRESS <u>M. D. VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>3-11-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/12/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant Cemetery</u>		LOCATION (City, town, or county) (State) <u>Mardela Springs, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3/14/55</u>		REGISTRAR'S SIGNATURE <u>Wm. B. Vandegriff</u>		24. FUNERAL DIRECTOR <u>Arlington S. Phillips</u>		ADDRESS <u>1808 N. Monroe St., Baltimore 17, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Released at Baltimore, Md.



2353

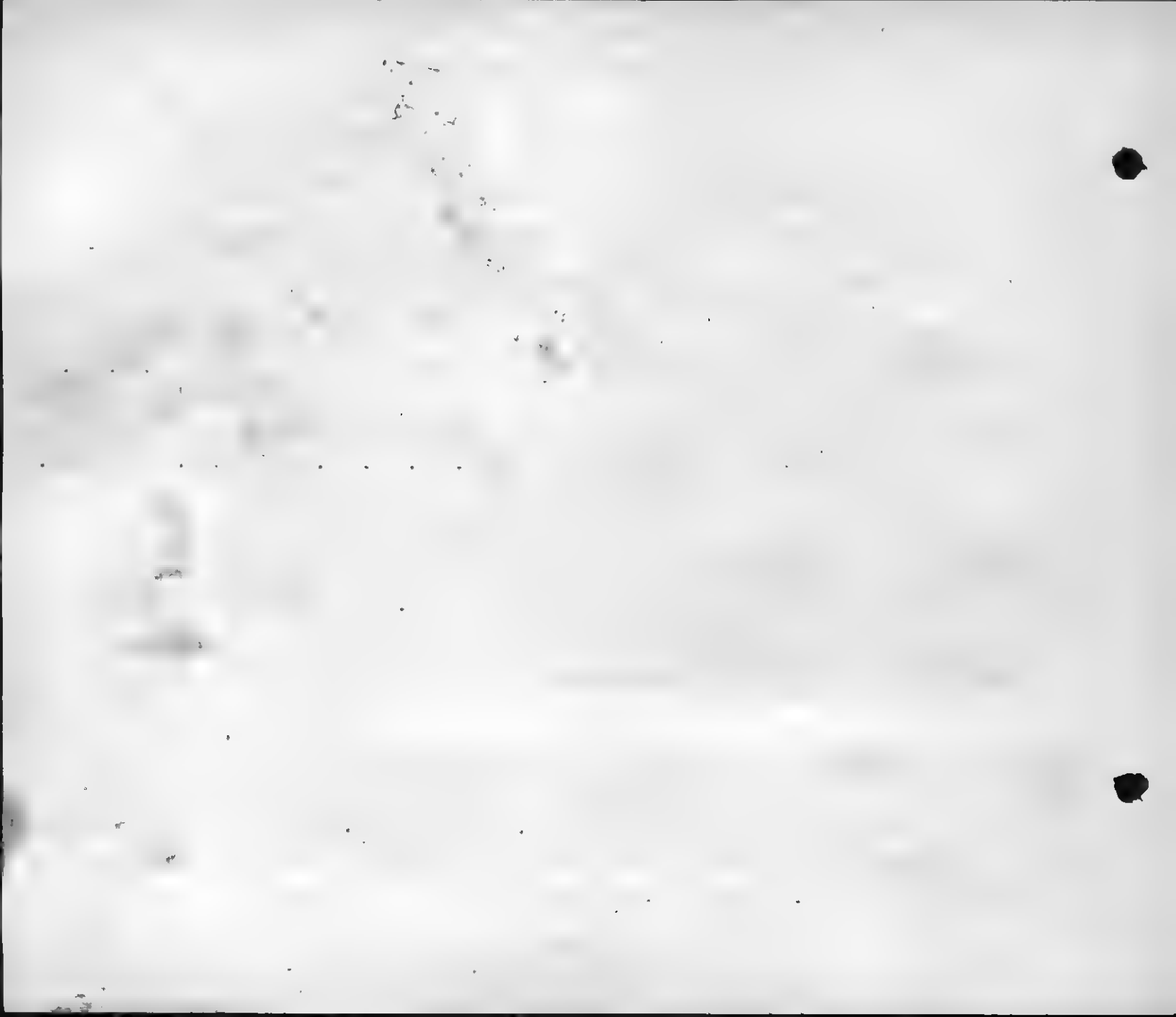
## CERTIFICATE OF DEATH

Reg. Dist. No. *XX*

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<i>X</i> TOWN <u>Fort Howard</u>		<u>4</u> Days		OR TOWN <u>Baltimore</u> <i>3V01-4</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>2322 Cambridge Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH			
<u>JOSEPH</u> (NMI) <u>COOK</u>				<u>March</u> <u>16</u> , <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Divorced</u>		8. DATE OF BIRTH: <u>March 26, 1888</u>	
9. AGE last birthday: <u>66</u> yrs.		10. AGE last birthday: <u>66</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Manning Meat Pack.</u>			
13. FATHER'S NAME: <u>Joseph Cook</u>				14. MOTHER'S MAIDEN NAME: <u>Mary MN: Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service) <u>Yes</u> <u>WW-I</u>				16. SOCIAL SECURITY NO. <u>220-09-0462</u>			
17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.</u>							
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
+20.1 IMMEDIATE CAUSE				(A) MYOCARDIAL INFARCTION			
ANTECEDENT CAUSE (B):				DUE TO ARTERIOSCLEROTIC CORONARY THROMBOSIS			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
VA M.							
22. I hereby certify that I attended the deceased from <u>Mar. 12, 1955</u> , to <u>Mar. 16, 1955</u> , that I last saw the deceased <u>at 7:20 AM</u> , and that death occurred at <u>7:20 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Irving Freeman</u> ADDRESS <u>VAH, Fort Howard, Md.</u> DATE SIGNED <u>3-16-55</u>							
IRVING FREEMAN, M.D. Acting Chief, Medical Service VAH, Fort Howard, Md. 3-16-55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>MAR. 21, 1955</u>		<u>Baltimore National Cemetery</u>		<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3-17-55</u>		<u>A.D. Hedrick</u>		<u>Wm. Cook-Bright Inc.</u>		<u>6009 Harford Road, Baltimore 14, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2354

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02331

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Bullo</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikeville</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikeville 8, md</u>			
X TOWN				X TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>815 Temple Cliff Road</u>				STREET ADDRESS (If rural, give location) <u>815 Temple Cliff Road</u>			
3. NAME OF DECEASED (Type or Print) <u>Edna</u>		(First) <u>Marie</u>		(Last) <u>Cooper</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>4</u> (Year) <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>Apr 25, 1896</u>	9. AGE last birthday <u>58</u> yrs.	If under 1 year: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R. W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Parkton, md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin</u>		<u>Slippler</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Frances Spicer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT <u>Mrs. Edith Berner, daughter</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
156.1 Immediate cause (a) <u>Carcinoma - liver</u>							
Antecedent cause(s) (b) <u>—</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>—</u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION <u>March 1954</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma liver to metastasize</u>					
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>18 Jan</u> , 19 <u>55</u> , to <u>4 March</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4 March</u> , 19 <u>55</u> , and that death occurred at <u>4 P.</u> m., from the causes and on the date stated above.							
SIGNATURE <u>Charles H. Williams</u>				ADDRESS <u>1632 Reis Rd, Pikeville 7 March 55</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3-7-55</u>		NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u>		LOCATION (City, town, or county) (State) <u>Rayville Md</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>		24. FUNERAL DIRECTOR <u>Frank H. Newell</u>		ADDRESS <u>Pikeville Md</u>	

EJ.

RECEIVED

U. S.

2355

MARYLAND STATE DEPARTMENT OF HEALTH

02332

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MARYLAND</b> COUNTY <b>BALTO</b>	
55 CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>TOWSON</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>RURAL TOWSON</b>	
100 HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>1666 YAKONA AVE.</b>		STREET ADDRESS (If rural, give location) <b>1666 YAKONA AVE</b>	
3. NAME OF DECEASED (Type or Print) <b>FANNIE M. CORSI</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>MARCH 31 1955</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>MARCH 28 1910</b>
9. AGE last birthday <b>45</b> yrs.		11. BIRTHPLACE (State or foreign country) <b>ITALY</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BENDIX CORP.</b>	
12. FATHER'S NAME <b>VINCENT MODO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. MOTHER'S MAIDEN NAME <b>RASALIE GIORDANO</b>		14. MOTHER'S MAIDEN NAME <b>RASALIE GIORDANO</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY No. <b>217-08-6560</b>	
17. INFORMANT AND ADDRESS <b>FREDERICK CORSI 1666 YAKONA AVE</b>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
175X Immediate cause (a) <b>Respiratory failure</b>		
Antecedent cause(s) (b) <b>Carcinoma of the lung - generalized metastases</b>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>metastases</b>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <b>SUICIDE</b>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb 25, 1955, to March 31, 1955, that I last saw the deceased alive on March 25, 1955, and that death occurred at 2:25 P.M., from the causes and on the date stated above.

SIGNATURE <b>Charles J. Black M.D.</b>		ADDRESS <b>914 N. Charles St. 4/1/55</b>	
23. BURIAL - CREMATION REMOVAL (Specify) <b>BURIAL</b>		DATE <b>APR 4 1955</b>	
NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER CEM</b>		LOCATION (City, town, or county) (State) <b>4430 BELAIR RD MD.</b>	
DATE REC'D BY LOCAL REG. <b>April 2, 1955</b>		24. FUNERAL DIRECTOR ADDRESS <b>Duffel Bldg 1800 E LOMBARD ST.</b>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NO. 12345 6789 10111 12131 14151

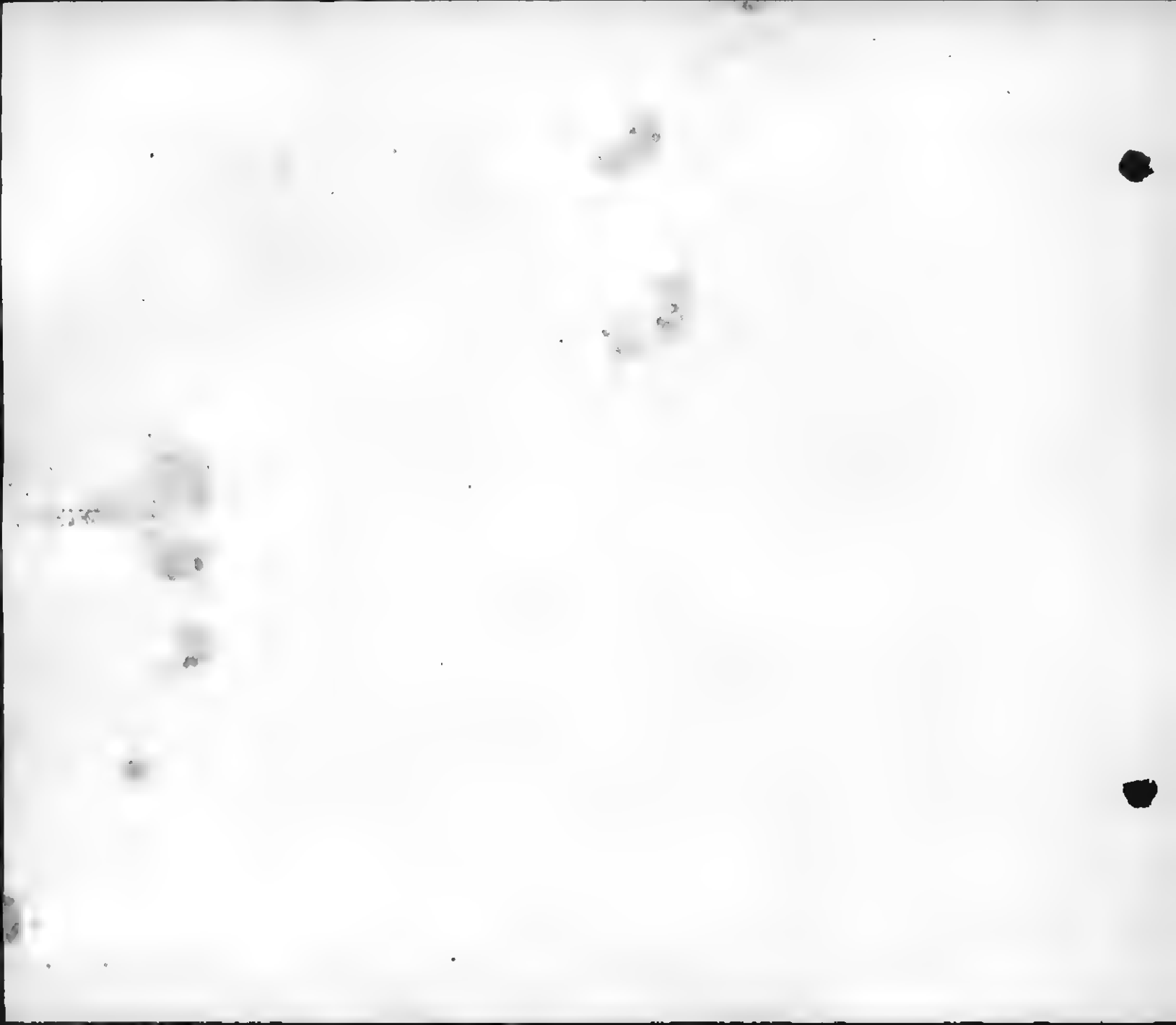
2356

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Balto.</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Balto.</b>	
CITY (If outside corporate limits, write and give nearest town) <b>Woodlawn</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		OR TOWN <b>Woodlawn</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>2631 Purnell Drive</b>				STREET ADDRESS (If rural give location) <b>2631 Purnell Drive</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>BESSIE COVEY</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>March 3, 1955</b>			
5. SEX: <b>female</b>	6. COLOR OR RACE: <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Widowed</b>	8. DATE OF BIRTH: <b>Aug. 21, 1888</b>	9. AGE last birthday: <b>66</b> yrs.	10. IF UNDER 1 YEAR: Months Days	11. IF UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>retired Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY: <b>at home</b>		11. BIRTHPLACE (State or foreign country): <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME: <b>Joseph Aaron</b>				14. MOTHER'S MAIDEN NAME: <b>Bertha</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>			
17. INFORMANT & ADDRESS: <b>Mrs. David C. Lasher - 2631 Purnell Dr.</b>							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
260X IMMEDIATE CAUSE (A) <b>Coronary Thrombosis</b>							
ANTECEDENT CAUSE (B) <b>Arteriosclerotic Cardio-Vascular Dis. 1 1/2 yrs</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <b>Diabetes</b>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <b>No operation</b>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?							
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <b>Oct 8, 1953</b> to <b>March 3, 1955</b> , that I last saw the deceased alive on <b>March 3, 1955</b> , and that death occurred at <b>10:25 PM</b> , from the causes and on the date stated above.							
SIGNATURE: <b>Joshua H. Armacost</b>				DATE SIGNED: <b>3-5-55</b>			
ADDRESS: <b>6419 Woodlawn Rd</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <b>Burial</b>				DATE THEREOF: <b>3/7/55</b>			
NAME OF CEMETERY OR CREMATORY: <b>Ft. Lincoln Cem.</b>				LOCATION (City, town, or county) (State): <b>Prince George's Co., Md.</b>			
DATE REC'D BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE: <b>Wm. J. Dickman</b>			
FUNERAL DIRECTOR ADDRESS: <b>Wm. J. Dickman &amp; Sons - Balto 17</b>							

MARGIN RESERVED FOR BINDING



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2357

02334

Reg. Dist.

No. 30

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>CATONSVILLE</u>		LENGTH OF STAY (in this place) <u>4 yrs.</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>BALTIMORE</u>		<u>3/1/14</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SPRING GROVE STATE HOSPITAL</u>				STREET ADDRESS (If rural, give location) <u>933 W. Lexington St.</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>THEODORE</u>		(Middle) <u>CZAK</u>		(Last) <u>CZAK</u>		(Month) (Day) (Year) <u>3 - 13 - 19 55</u>	
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>SINGLE UNKNOWN</u>		8. DATE OF BIRTH:	
				9. AGE last birthday: <u>approx 63 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>AUSTRIA</u>	
12. CITIZEN OF WHAT COUNTRY: <u>AUSTRIA</u>							
13. FATHER'S NAME: <u>JULIUS CZAK</u>				14. MOTHER'S MAIDEN NAME: <u>MARIA PARAGE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>acute cardiac failure due to</u> DUE TO							
Antecedent cause(s) (b) <u>coronary occlusion</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town), (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Walter H. Kieffer</u>		1010 Redman		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Mar. 13 1955</u>	
DEPUTY MEDICAL EXAMINER		ASSISTANT MEDICAL EXAM.					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>buried</u>		DATE THEREOF: <u>3/16/55</u>		NAME OF CEMETERY OR CREMATORY: <u>University Hospital</u>		LOCATION (City, town, or county) (State): <u>Balto, Md.</u>	
DATE REC'D BY LOCAL REG. <u>3-16-55</u>		REGISTRAR'S SIGNATURE: <u>T.E. Harry</u>		24. FUNERAL DIRECTOR: <u>Wm. F. H. Hendley</u>		ADDRESS: <u>578 W. Middle St.</u>	

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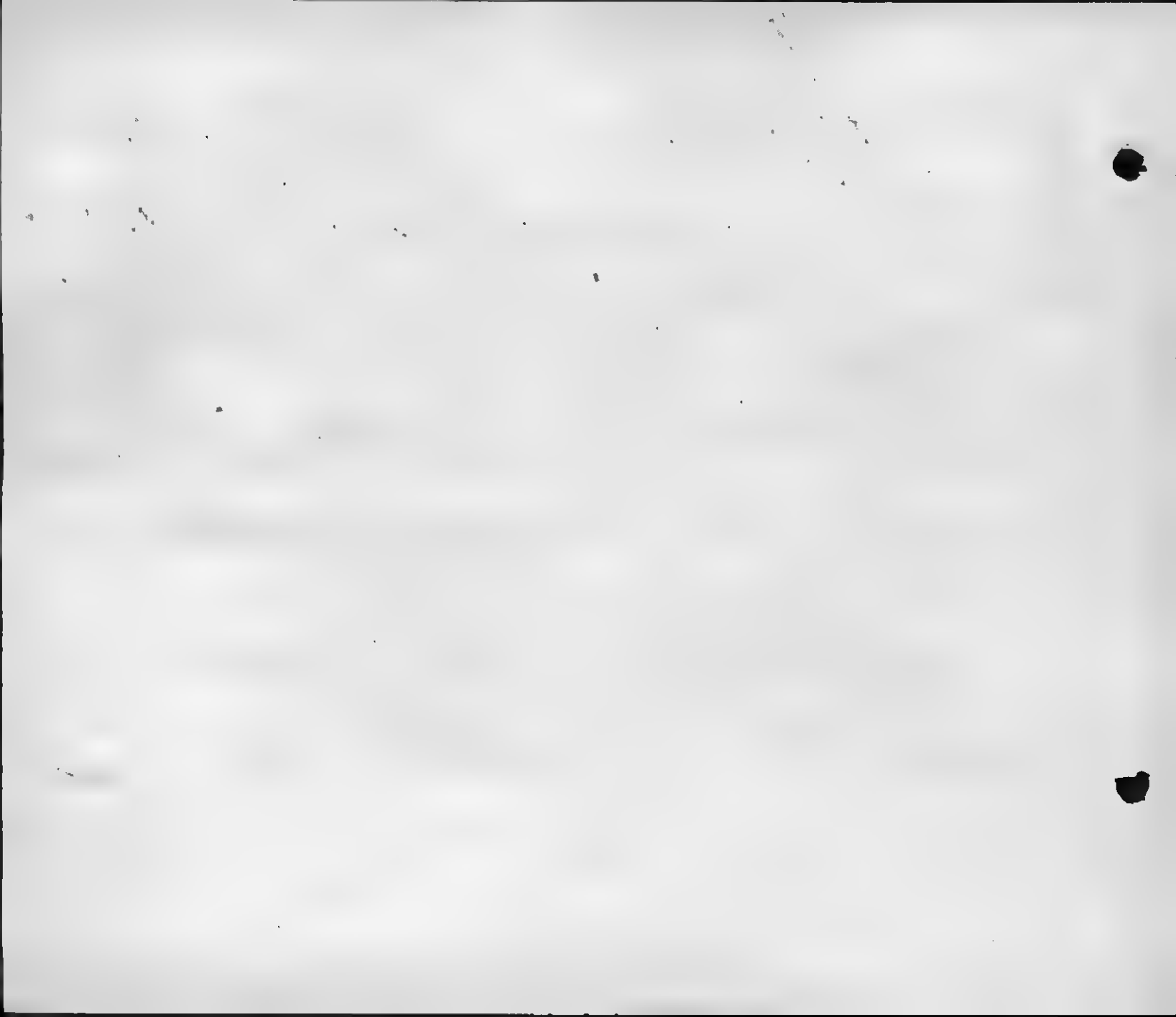
## CERTIFICATE OF DEATH

Reg. Dist. No. 3

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>	STATE <u>Md</u> COUNTY <u>Baltimore</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ridgewood Manor</u>	LENGTH OF STAY (in this place)	STREET ADDRESS <u>1534 Roundshell Rd</u>	(If rural give location)
3. NAME OF DECEASED. (Type or Print) <u>Russella A. Dare</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>3 14 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>July 29/68</u>
9. AGE last birthday: <u>89</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Richard Dare</u>		14. MOTHER'S MAIDEN NAME: <u>Caroline Shemwell</u>	
15. WAS DECEASED EVER IN U.S. ARMY OR NAVY (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT & ADDRESS: <u>Mrs E. F. Watters, Jr. / Balto</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) <u>Arteriosclerotic Cardiovascular Disease</u>		11 yrs.	
ANTECEDENT CAUSE (B) <u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</u>			
(C) <u>Arteriosclerosis, Cerebral, with Hypertension</u>		2 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>—</u>		19B. MAJOR FINDINGS OF OPERATION: <u>—</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-14</u> , 19 <u>54</u> , to <u>3-15</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3-14</u> , 19 <u>55</u> , and that death occurred at <u>7:05 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>John F. Schaefer</u>		DATE SIGNED <u>3-15-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-16-55</u>		24. FUNERAL DIRECTOR <u>Stewart Mortuary</u>	
REGISTRAR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.



2359

02336

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

No. 33

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Baltimore		STATE	Md.	
	MARYLAND		COUNTY	Carroll	
CITY (If outside corporate limits, write RURAL OR and give nearest town)			CITY (If outside corporate limits write RURAL and give nearest town)		
X TOWN Owings Mills			TOWN Westminster		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
Rosewood School			230 E. Main		
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First)	(Middle)	(Last)	(Month)	(Day)	(Year)
Raymond Shipley Davis			March 20, 1955		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	10. IF UNDER 1 YEAR
Male	White	Married	March 19, 1911	44 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):			11. BIRTHPLACE (State or foreign country):		
Shift Engineer			Carroll County U.S.		
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
William E. Davis			Pearl G. Shipley		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.:		
No			217-09-2042		
17. INFORMANT & ADDRESS:			230 E. Main Street		
			Audrey K. Davis, Westminster, Md.		

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				35 min.	
Immediate cause (a) Asphyxiation due to being buried in soft DUE TO coal in silo					
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. none					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY?	
none		none		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.)		21c. (City or town) (County) (State)	
		INJURY Coal silo, Owings Mills		Balto. Md.	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR	
3-20-55 10:30 A.				While knocking coal loose, fell & was buried in coal.	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		M. D.			
D. D. Coates		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3-25-55 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		LOCATION (City, town, or county) (State)	
Burial		Mar. 23, 1955		Deer Park Carroll County	
DATE RECD BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
3-22-55		Mary B. Elmer		J. E. Meyers, Westminster, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

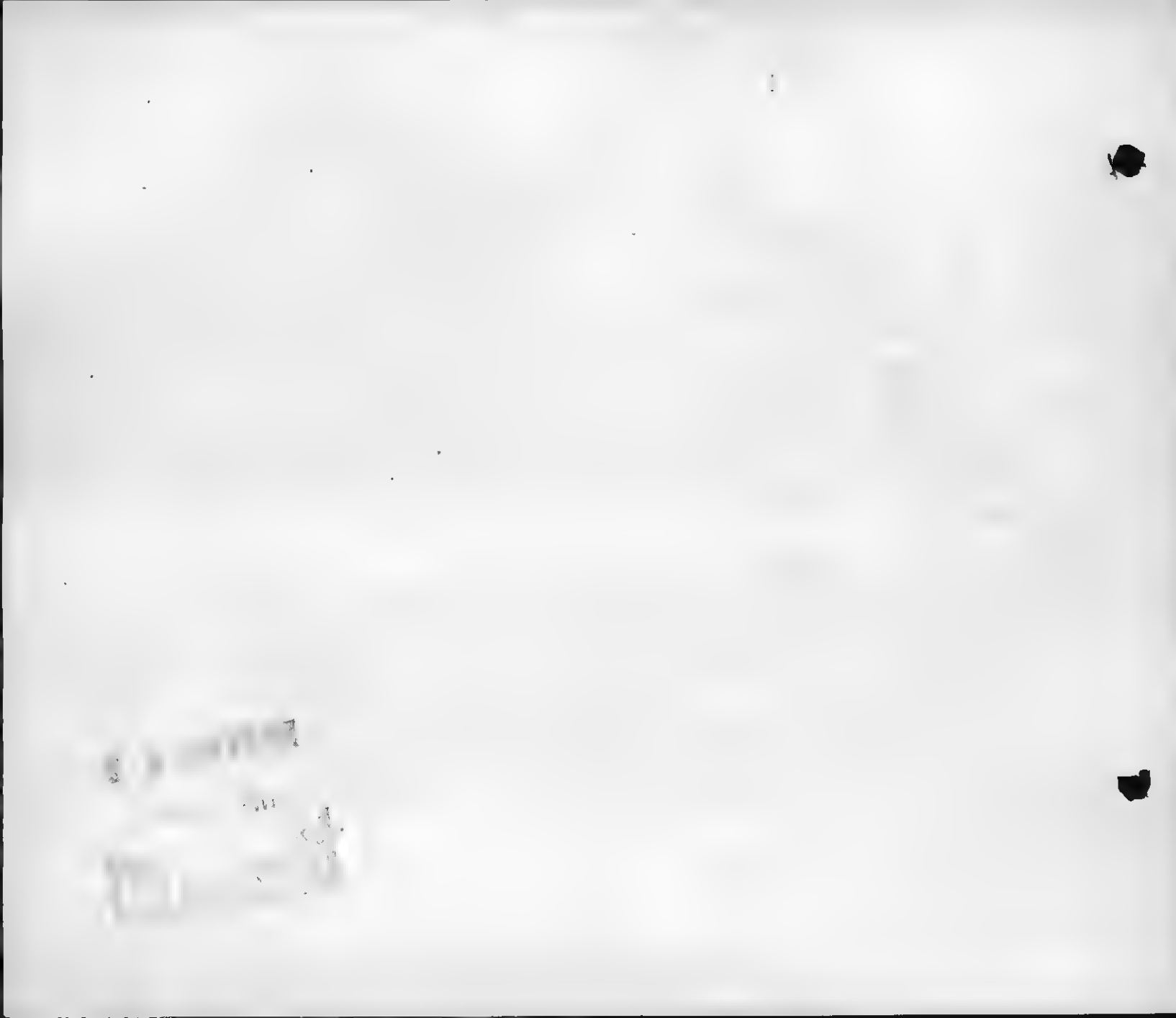
2360

## CERTIFICATE OF DEATH

Reg. Dist. No.

02337

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>52</u> TOWN <u>Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hosp Catonsville, Md.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Prince George</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>4831 St. Barnabus Road</u> TOWN <u>Washington 21, D.C.</u> STREET ADDRESS " " " "	
3. NAME OF DECEASED: (Type or Print) <u>Arletta NMI DERRY</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>March 26 19 55</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>Caucasian</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>		8. DATE OF BIRTH: <u>April 6, 1871</u>	
9. AGE last birthday: <u>83</u> yrs		10. MONTHS: <u>83</u> Months	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>		12. KIND OF BUSINESS OR INDUSTRY: <u>Virginia</u>	
13. FATHER'S NAME: <u>Richard Marshall</u>		14. MOTHER'S MAIDEN NAME: <u>Virginia Alder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If yes, give war or dates of service: <u>no</u>		16. SOCIAL SECURITY NO.: <u>?</u>	
17. INFORMANT'S ADDRESS: <u>Mrs. Louise M Marland - daughter Washington 21, D.C.</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE: <u>420.1</u>		<u>3 wks</u>	
ANTECEDENT CAUSE (S):		<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		<u>Arteriosclerotic cardiovascular dis.</u>	
(A) <u>Myocardial infarction</u>		<u>associated with Senility</u>	
(B) <u>Arteriosclerotic cardiovascular dis.</u>		<u>1-2 mos.</u>	
(C) <u>associated with Senility</u>		<u>Non-healing bed sores</u>	
19. DATE OF OPERATION: <u>none</u>		20. AUTOPSY: YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, office bldg., etc.) OF INJURY: <u>none</u>	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>none</u>		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>July 19, 1954</u>	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Mar. 26, 19 55</u>	
22. I hereby certify that I attended the deceased from <u>Mar 26, 19 55</u> to <u>Mar. 26, 19 55</u> (that I last saw the deceased alive on <u>Mar 26, 19 55</u> , and that death occurred at <u>6:30pm</u> )		23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u>	
DATE THEREOF: <u>3/29</u>		NAME OF CEMETERY OR CREMATORY: <u>St. Elizabeth</u>	
LOCATION (City, town, or county): <u>Loudon County Va</u>		24. FUNERAL DIRECTOR: <u>Hall Funeral Home</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>3-27-55</u>		REGISTRAR'S SIGNATURE: <u>V.E. Harry</u>	
ADDRESS: <u>M.D. Spring Grove State Hosp 3-26-55</u>		ADDRESS: <u>James B. Simpson</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

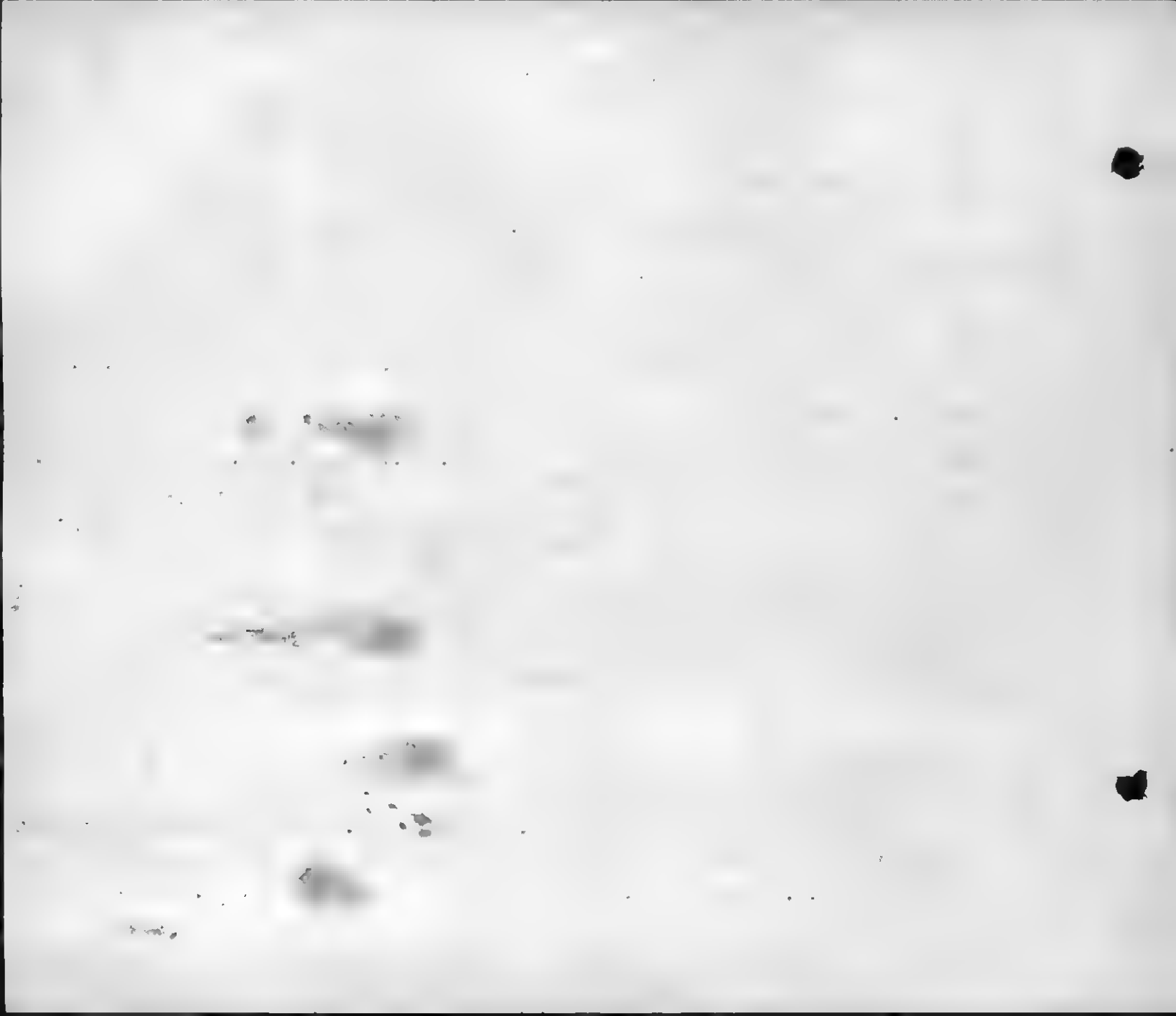
02338

2361

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <b>Fort Howard</b>		<b>52 Days</b>		TOWN <b>Baltimore</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Veterans Administration Hosp.</b>				STREET ADDRESS (If rural give location) <b>4013 Overlea Avenue</b>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<b>SAMUEL J. DEXTER</b>				<b>March 10 19 55</b>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<b>Male</b>	<b>White</b>	<b>Married</b>	<b>8-29-99</b>	<b>55</b> yrs	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Engineer</b>			10B. KIND OF BUSINESS OR INDUSTRY: <b>Railroad</b>		11. BIRTHPLACE (State or foreign country): <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME: <b>Samuel A. Dexter</b>				14. MOTHER'S MAIDEN NAME: <b>Lilly Price</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give year or dates of service) <b>Yes WW-1</b>				16. SOCIAL SECURITY NO. <b>717-07-8791</b>		17. INFORMANT & ADDRESS: <b>Clin. Rec., Vet. Adm. Hosp. Fort Howard, Md.</b>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Approx. <b>9 MONTHS</b>	
IMMEDIATE CAUSE (A) <b>CARCINOMA OF PANCREAS WITH METASTASES TO LIVER</b>							
ANTECEDENT CAUSE (B) <b>TO LIVER</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <b>2/9/55</b>		19B. MAJOR FINDINGS OF OPERATION: <b>Cholecystojejunostomy and jejunojejunostomy Findings: Carcinoma of pancreas with metastases to liver</b>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
<b>VA</b>							
22. I hereby certify that I attended the deceased from <b>Jan. 17, 1955</b> , to <b>Mar. 10, 1955</b> , and that death occurred at <b>12:24 AM</b> , from the causes and on the date stated above.							
SIGNATURE <b>Irving Freeman</b>		ADDRESS		DATE SIGNED <b>3-10-55</b>			
<b>IRVING FREEMAN, M.D., Acting Chief, Medical Service VAH, Fort Howard, Md.</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>3/14/55</b>		NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <b>[Signature]</b>		24. FUNERAL DIRECTOR: <b>Lassahn Funeral Home 7401 Belair Road Baltimore, Maryland</b>			





2362

MARYLAND STATE DEPARTMENT OF HEALTH

02339

# CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Fort Howard</b>		LENGTH OF STAY (In this place) <b>70 Minutes</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Veterans Administration Hospital</b>				STREET ADDRESS (If rural, give location) <b>635 W. Fayette Street</b>	
3. NAME OF DECEASED (Type or Print) <b>JOSEPH</b>		(First) <b>E.</b> (Middle)		4. DATE (Month) (Day) (Year) OF DEATH <b>March 7, 1955</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	
8. DATE OF BIRTH <b>11/11/87</b>		9. AGE last birthday <b>67</b> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Produce Huckster</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Elkridge, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>John R. Dicus</b>		14. MOTHER'S MAIDEN NAME <b>Susan R. Watts</b>	
15. WAS DECEASED EVEN IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY No. <b>216-08-8129</b>		17. INFORMANT AND ADDRESS <b>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</b>	

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

**SENILITY AND MALNUTRITION**

Antecedent cause(s)

Disease or condition, if any, giving rise to the above cause stating the underlying cause last

(b)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☒ No ☐21. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.PLACE (Home, farm, factory, street, OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURYINJURY OCCURRED  
While at Not while  
work at work

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

William Carmichael, M.D.

Deputy Medical Examiner

Baltimore, Md.

22 Mar 1955

23. BURIAL, CREMATION  
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL  
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

3/15/55

A. H. Heluch Jr

John E. Teufel &amp; Son Funeral Home

5311 Edmonds Ave., Baltimore, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the uses of death clearly and legibly.

VS. A15A

TWO FOR ONE CERTIFICATE - Film G178 - 3/15/55 - mnb

Originally received on regular VSA15 - Should have been  
medical examiner's certificate.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2363

## CERTIFICATE OF DEATH

Reg. Dist. No. 5

02340

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>TOWSON</u>				TOWN <u>TOWSON</u> <u>417 Alabama Rd.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: <u>BERTHA LOUISE DODSON</u>				OF DEATH: <u>March 26, 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>		8. DATE OF BIRTH: <u>Oct. 21, 1872</u>	
				9. AGE last birthday: <u>82</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Mason Robert</u>				14. MOTHER'S MAIDEN NAME: <u>Helen Trumbower</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Family Informant</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
(B)							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
2. I hereby certify that I attended the deceased from <u>Nov. 2, 1953</u> , to <u>March 26, 1955</u> , that I last saw the deceased alive on <u>March 26, 1955</u> and that death occurred at <u>7:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Lawrence C. Post M.D.</u>				ADDRESS <u>M.D. 6805 York Rd. Baltimore Md.</u>			
DATE SIGNED <u>3/27/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Mar. 27, 1955</u>		<u>Mar. 27, 1955</u>		<u>John Burns' Son,</u>		<u>Baltimore, Md.</u>	

BOLTON V. S.

MAR



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **02341**  
**2364** **CERTIFICATE OF DEATH**

Reg. Dist. No. *xxi*

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>6 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1934 W. Lafayette Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>JAMES H. DOUGLASS</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>March 28 19 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>December 24, 1905</u>	9. AGE last birthday <u>49</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Receptionist</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Steamship Company</u>		11. BIRTHPLACE (State or foreign country): <u>Gloucester, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>James Douglass</u>				14. MOTHER'S MAIDEN NAME: <u>Susie Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW-II</u>				16. SOCIAL SECURITY NO. <u>220-12-8672</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp. Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						UNKNOWN	
IMMEDIATE CAUSE (A) <u>RIGHT SIDED HEART FAILURE</u>						UNKNOWN	
ANTECEDENT CAUSE (B) <u>CHRONIC PULMONARY EMBOLUS</u>						LIFE	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>DUE TO SICKLE CELL ANEMIA</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 22, 19 55</u> to <u>Mar. 28, 19 55</u> , and that death occurred at <u>10:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>WILLIAM B. VANDEGRIFT, M.D.</u>				ADDRESS <u>M. DVAH, Fort Howard, Maryland 3-29-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-1-55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery Baltimore, Maryland</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>3-29-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Charles R. Law Funeral Home</u>		ADDRESS <u>802 Madison Ave., Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2365

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

02342

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <b>BALTIMORE COUNTY</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>MARYLAND</b> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>TOWSON</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>TOWSON</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>8121 PLEASANT PLAINS RD.</b>		STREET ADDRESS (If rural, give location) <b>8121 PLEASANT PLAINS ROAD</b>	
3. NAME OF DECEASED (Type or Print) <b>PAULINE ENGLER</b>		4. DATE OF DEATH <b>MARCH 23, 1955</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>SEPT. 12, 1869</b>
9. AGE last birthday <b>85</b> yrs.		10. If under 1 year: Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If year, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY No. <b>NONE</b>	
17. INFORMANT AND ADDRESS <b>MRS THOMAS SINGMAN</b>		18. SAME <b>SAME</b>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		15. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <b>Cerebral Arteriosclerosis</b>			
Antecedent cause(s) (b) <b>Aortic Regurgitation</b>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>Myocardial Infarction</b>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <b>None</b>		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from Dec 14, 1937, to 3/23, 1955, that I last saw the deceased alive on 3/23, 1955, and that death occurred at 10 21/2 m., from the causes and on the date stated above.

SIGNATURE D. Daniel Miller M.D. ADDRESS 4570 Stanford Rd. Back 14-Md DATE SIGNED

23. BURIAL, CREMATION, or other disposal (Specify) **BURIAL** DATE **MARCH 26, 1955** NAME OF CEMETERY OR CREMATORY **MORELAND MEMORIAL** LOCATION (City, town, or county) **BALTIMORE COUNTY** (State)

DATE RECD BY LOCAL REG 3/25/55 REGISTRAR'S SIGNATURE A. W. Hedrick 24. FUNERAL DIGNITY & SONS INC. ADDRESS BALTIMORE MARYLAND Seay P. Dandridge





PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2366

CERTIFICATE OF DEATH

02343

Reg. Dist. No. 41

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Baltimore</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>X TOWN Fort Howard</b>	LENGTH OF STAY (in this place) <b>8 Days</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR <b>TOWN Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>50 Veterans Administration Hospital</b>		STREET ADDRESS (If rural give location) <b>1325 Shield Place, Baltimore 17</b>	
3. NAME OF DECEASED: (First) (Middle) (Last) <b>ROBERT HENRY EPPS</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>March 8, 19 55</b>	
5. SEX. <b>Male</b>	6. COLOR OR RACE: <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>April 21, 1893</b>
9. AGE last birthday <b>61</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 20 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Odd Jobs</b>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <b>Norfolk, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Edward Epps</b>		14. MOTHER'S MAIDEN NAME: <b>Henrietta MN: Devall</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>WW-I</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT & ADDRESS: <b>Clin. Rec. Vet. Adm. Hospital, Fort Howard, Md.</b>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
332X IMMEDIATE CAUSE		1 WEEK	
ANTECEDENT CAUSE (B)		1 WEEK	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>VA M.</b>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb. 28 1955, to Mar. 8, 1955, and that death occurred at 4:30 A.M. from the causes and on the date stated above.			
SIGNATURE <b>WILLIAM B. VANDEGRIFT, M.D.</b>		ADDRESS <b>M. D. VAH, FORT HOWARD, MARYLAND 3-8-55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>3/12/1955</b>	
NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR <b>Arlington S. Phillips, 1808 N. Monroe St. Baltimore 17, Md.</b>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

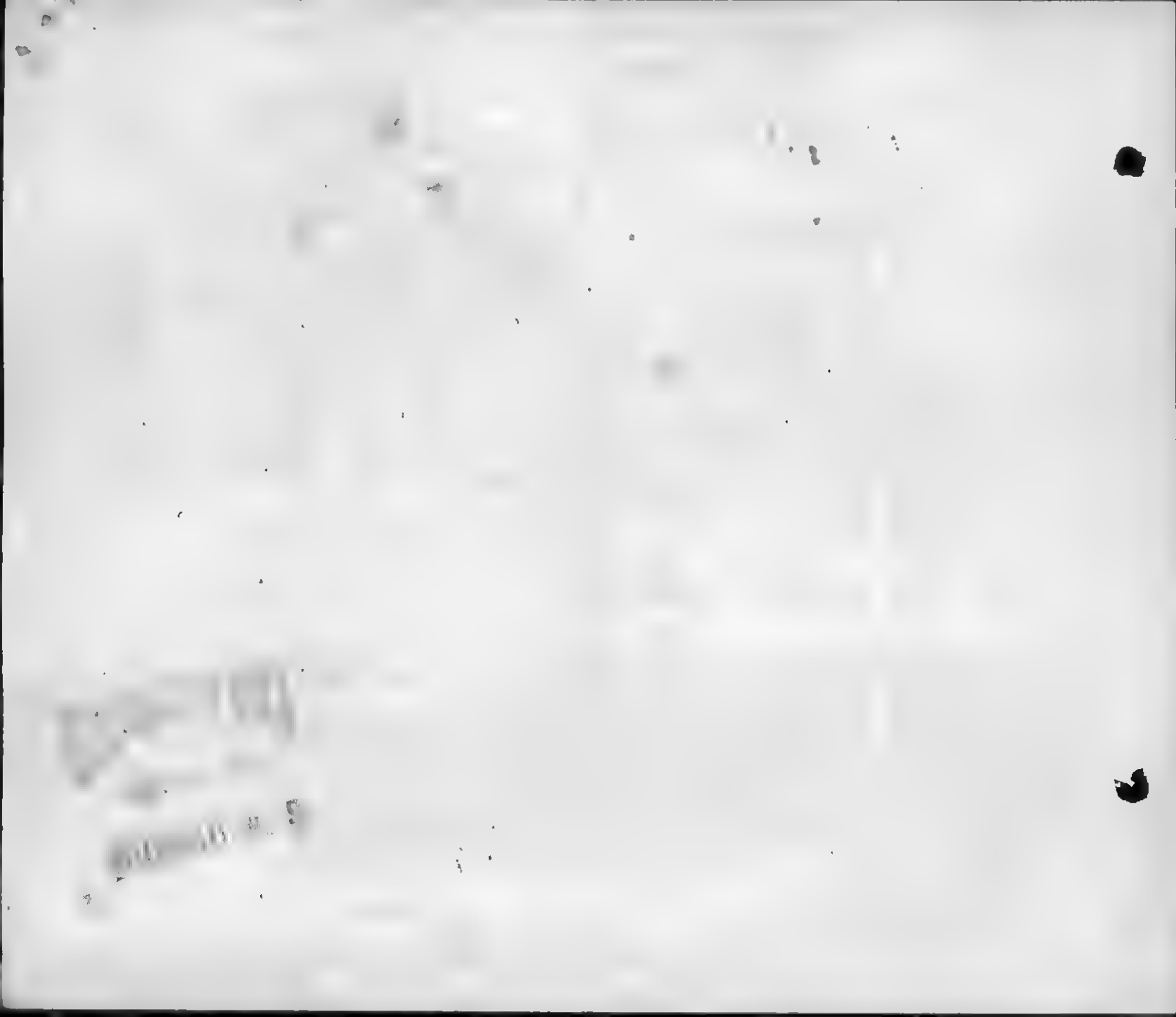
2367

## CERTIFICATE OF DEATH

02319

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND	CITY (If outside corporate limits, write RURAL OR TOWN <u>Catonsville</u> )	STATE <u>Md.</u> COUNTY <u>Anne Arundel</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mayo</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove Hosp</u>		STREET ADDRESS (If rural give location) <u>Cox</u>	
3. NAME OF DECEASED: (First) <u>Virginia</u> (Middle) <u>May</u> (Last) <u>Buane</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Mar 16 1958</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>5-10-1877</u>
9. AGE last birthday <u>77</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HV</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>George Gaden</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Jackson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.): <u>No</u> If Yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT'S ADDRESS: <u>Hosp. Records</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>			<u>2 mo</u>
ANTECEDENT CAUSE (B) <u>Arterio sclerotic C.V. Dis</u>			<u>-</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile Psychosis</u>			<u>7 yrs</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 13, 1948</u> to <u>Mar 16, 1958</u> , that I last saw the deceased alive on <u>Mar 16, 1958</u> , and that death occurred at <u>4 15 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Frederick L. Phillips</u>		M.D. <u>Spring Grove Hosp</u> DATE SIGNED <u>3/16/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-18-58</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Andrews</u>		LOCATION (City, town, or county) <u>Mayo, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3/16/58</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>	
24. FUNERAL DIRECTOR <u>T.A. Hardesty &amp; Son</u>		ADDRESS <u>Mayo, Md.</u>	



MARYLAND

2368

02344  
STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH- COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Md.</b> COUNTY <b>Balto.</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>near Randallstown</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>near Randallstown</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Marriottsville Rd.</b>		STREET ADDRESS (If rural, give location) <b>Marriottsville Rd.</b>	
3. NAME OF DECEASED (Type or Print) <b>MILDRED F. FAULKNER</b>		4. DATE OF DEATH (Month) <b>Mar.</b> (Day) <b>9,</b> (Year) <b>1955</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>married</b>	8. DATE OF BIRTH <b>June 16, 1905</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	9. AGE last birthday <b>49 yrs.</b>
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13. FATHER'S NAME <b>George W. Loudenslager</b>		14. MOTHER'S MAIDEN NAME <b>Katherine France</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <b>none</b>		16. SOCIAL SECURITY No. <b>Mr. Gene Faulkner - Marriottsville Rd.</b>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
442X Immediate cause		(a) <b>CEREBRAL VASCULAR ACCIDENT</b>		<b>1 DAY</b>	
Antecedent cause(s)		(b) <b>HYPERTENSIVE C.V. DISEASE, SEVERE &amp; RENAL INSUFFICIENCY</b>		<b>5 YEARS</b>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) ...			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

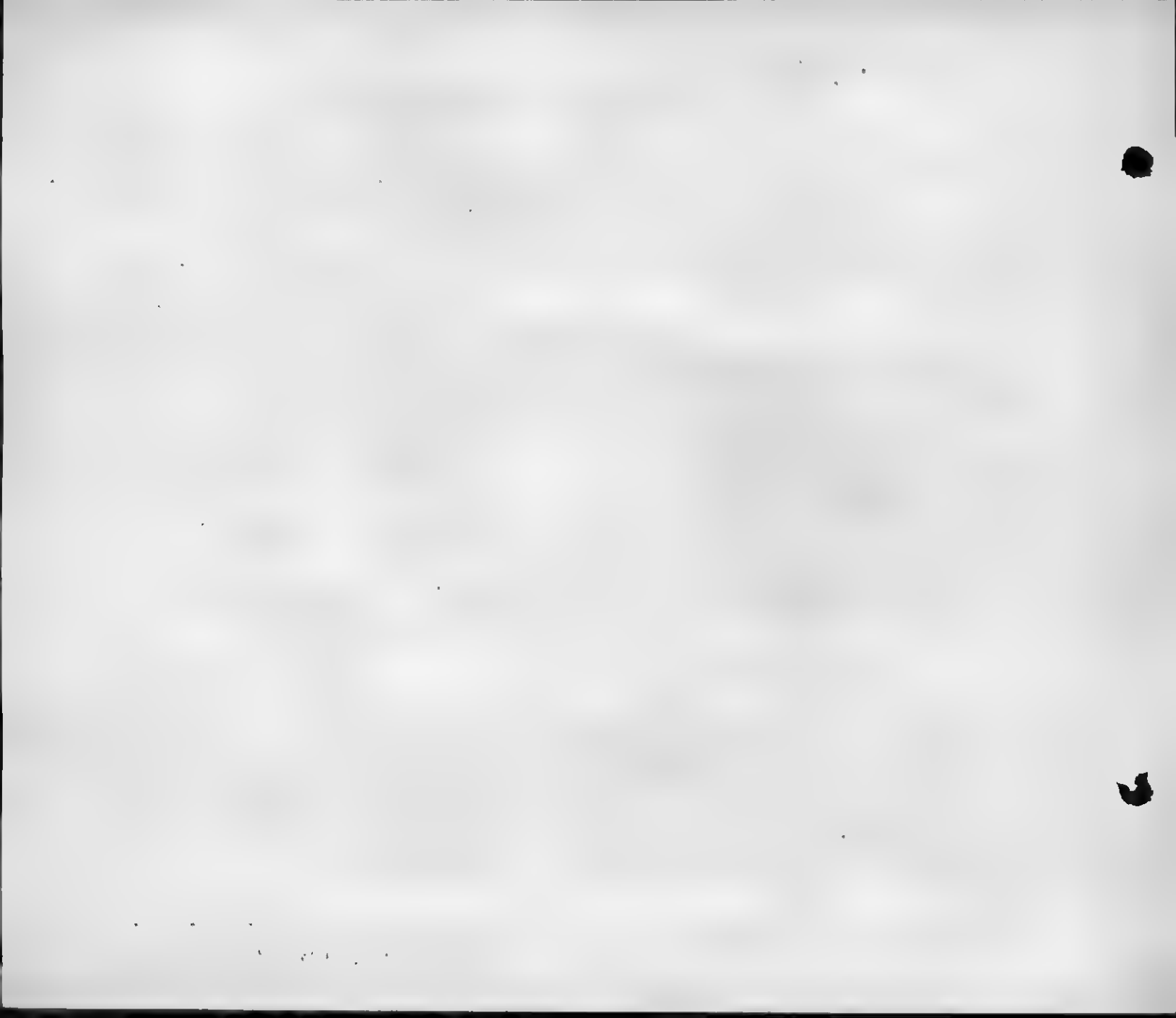
22. I hereby certify that I attended the deceased from **April**, 19**51**, to **MARCH 9**, 19**55**, that I last saw the deceased alive on **MARCH 9**, 19**55**, and that death occurred at **2 P** m., from the causes and on the date stated above.

SIGNATURE **Thomas E. Wheeler** (Degree or title) **MD** ADDRESS **Randallstown - Md - 3-105** DATE SIGNED **3-10-55**

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE <b>3/13/55</b>	NAME OF CEMETERY OR CREMATORY <b>Ward's Chapel</b>	LOCATION (City, town, or county) (State) <b>Balto. Co., Md.</b>
DATE REC'D BY LOCAL REG. <b>3/11/55</b>	REGISTRAR'S SIGNATURE <b>R. W. Hendrich</b>	24. FUNERAL DIRECTOR <b>Mr. J. T. Liskner</b>	ADDRESS <b>17</b>

MARGIN RESERVED FOR FINDING

1



2320

CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
CITY (If outside corporate limits, write RURAL and give nearest town) 51 Halethorpe  
OR TOWN 51 Halethorpe  
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4518 Spring Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Baltimore  
CITY (If outside corporate limits, write RURAL and give nearest town) 51 Halethorpe  
OR TOWN 51 Halethorpe  
STREET ADDRESS (If rural, give location) 4518 Spring Ave.

3. NAME OF DECEASED:

(First) Harry E. (Middle) Sender (Last) Sender

4. DATE OF DEATH:

(Month) Mar. (Day) 30 (Year) 1955

5. SEX:

Male

6. COLOR OR RACE:

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED:

Married

8. DATE OF BIRTH:

Feb. 4, 1896

9. AGE last birthday:

59 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Signalman

10b. KIND OF BUSINESS OR INDUSTRY:

Signal depot

11. BIRTHPLACE (State or foreign country):

Howard Co. Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Unknown

14. MOTHER'S MAIDEN NAME:

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service):

Yes WW I

16. SOCIAL SECURITY No.:

6-4-55

17. INFORMANT & ADDRESS:

Mrs. Mary E. Sender  
4518 Spring Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

434.1

Immediate cause

(a).....

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b).....

DUE TO

(c).....

MYOCARDIAL INFARCTION

CONGESTIVE HEART FAILURE

INTERVAL BETWEEN ONSET AND DEATH

1 WEEK

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 24 MARCH 1955, to 30 MARCH 1955, that I last saw the deceased alive on 30 MARCH 1955, and that death occurred at 8 P.....m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE)

ADDRESS

DATE SIGNED

George E. Guleau

MD

Chbridge 27 md 2 April 55

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

9-4-55

G. V. N. Smith

Funeral

1631 Davis Hill Ave.

MARGIN RESERVED FOR BINDING





2369

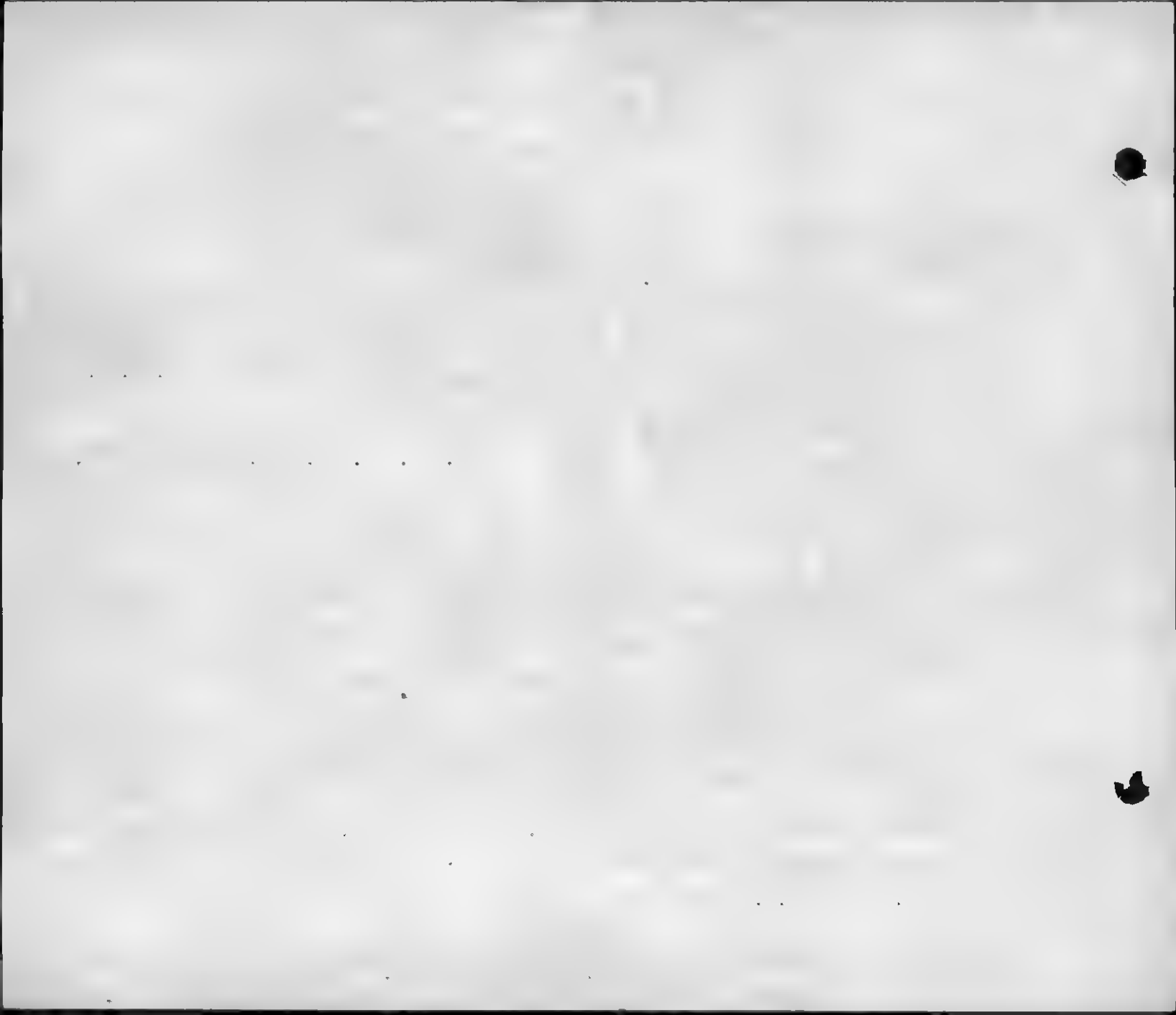
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>	STATE <u>Maryland</u> COUNTY	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>
OR TOWN <u>Fort Howard</u>	LENGTH OF STAY (in this place) <u>42 Days</u>	STREET ADDRESS (If rural give location)	<u>1109 West Franklin Street</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		DATE (Month) (Day) (Year) OF DEATH <u>March 31 1955</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>COLUMBUS H. FERRELL</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>March 31 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>October 12, 1912</u>
9. AGE last birthday <u>42</u> yrs. Months Days Hours Min.		10. AGE last birthday <u>42</u> yrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Bethlehem Steel</u>	
11. BIRTHPLACE (State or foreign country): <u>Catonsville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Charles Ferrell</u>		14. MOTHER'S MAIDEN NAME: <u>Charlotte Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> If Yes, give war or dates of service <u>VW II</u>		16. SOCIAL SECURITY NO. <u>215-03-9833</u>	
17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp. Fort Howard, Md.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>CHRONIC PASSIVE CONGESTION</u>		UNKNOWN	
ANTECEDENT CAUSE (S) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>		UNKNOWN	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>GLOMERULONEPHRITIS, CHRONIC</u>		UNKNOWN	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY OCCUR? <u>VAH, Fort Howard, Maryland</u>	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Feb. 17, 1955, to Mar. 31, 1955</u>	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb. 17, 1955, to Mar. 31, 1955</u> , and that death occurred at <u>1:25 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Francis G. Dickey</u>		ADDRESS <u>VAH, Fort Howard, Maryland</u>	
DATE-THEREOF <u>3-31-55</u>		DATE SIGNED <u>3-31-55</u>	
23. BURIAL, CREMATION, REMOVAL (IFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Western Star Cemetery</u>	
LOCATION (City, town, or county) (State) <u>Catonsville, Maryland</u>			
DATE REC'D BY LOCAL REGISTRAR <u>3-21-55</u>		REGISTRAR'S SIGNATURE <u>G. W. H. [Signature]</u>	
24. FUNERAL DIRECTOR <u>Charles R. Law Funeral Home</u>		ADDRESS <u>802 Madison Avenue, Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

02347

2370

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY <b>BALTIMORE</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>MARYLAND</b>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>TOWN FORT HOWARD</b>		LENGTH OF STAY (In this place) <b>D.O.A.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>TOWN BALTIMORE</b>		STREET ADDRESS (If rural, give location) <b>1805 Hope Street</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>		3. NAME OF DECEASED (Type or Print) <b>Joseph L. Field</b>		4. DATE OF DEATH (Month) <b>March</b> (Day) <b>8:30</b> (Year) <b>1955</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>1/6/91</b>	9. AGE last birthday <b>63</b> yrs.	If under 1 year Months   Days   Hours   Min.		If under 24 hrs. Hours   Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Armored Carrier</b>		11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Field</b>		14. MOTHER'S MAIDEN NAME <b>Rose McKeever</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>213-06-8590</b>	
17. INFORMANT AND ADDRESS <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>							

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1

Immediate cause

(a) CEREBRAL ACCIDENT

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

DIABETES MELLITUS

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR &amp; SONS, INC. ADDRESS

Baltimore, Maryland

Baltimore, Maryland

MARCH 1955 RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A



2371

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED  
(Type or Print)

ANNA H. FLINTHAM

2. DATE  
OF  
DEATH

March 24, 1955

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Balto. Co.*4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Mercy Villa

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

Mt. St. Agnes College

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

Aug. 1860

9. AGE (In years  
last birthday)

94

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Never employed

10B. KIND OF BUSINESS OR  
INDUSTRY

--

11. BIRTHPLACE (State or foreign country)

Philadelphia, Pennsylvania

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

WILLIAM FLINTHAM

14. MOTHER'S MAIDEN NAME

Caroline King

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

4310 Walnut Street  
Mrs. Oliver K. Reed, Philadelphia, Penna.

18.

422.1

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Arterio sclerotic cardio vascular  
disease

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

5 yrs.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., to or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22. I certify that (I) (this hospital) attended the deceased from Approximately March 24 1954 to March 24 1955, that (I) (we) last saw the deceased alive on March 24 1955, and that death occurred at 7:30 A. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

11 East Chase Street #2

23C. DATE SIGNED

3/25/55

ATTENDING PHYS. ☒MED. DIRECTOR ☒STAFF PHYS. ☐

M.D.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

3/26/55

24C. NAME OF CEMETERY OR CREMATORY

Old St. Ann's Cemetery

24D. LOCATION (City, town, or county)

Middletown, Delaware

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

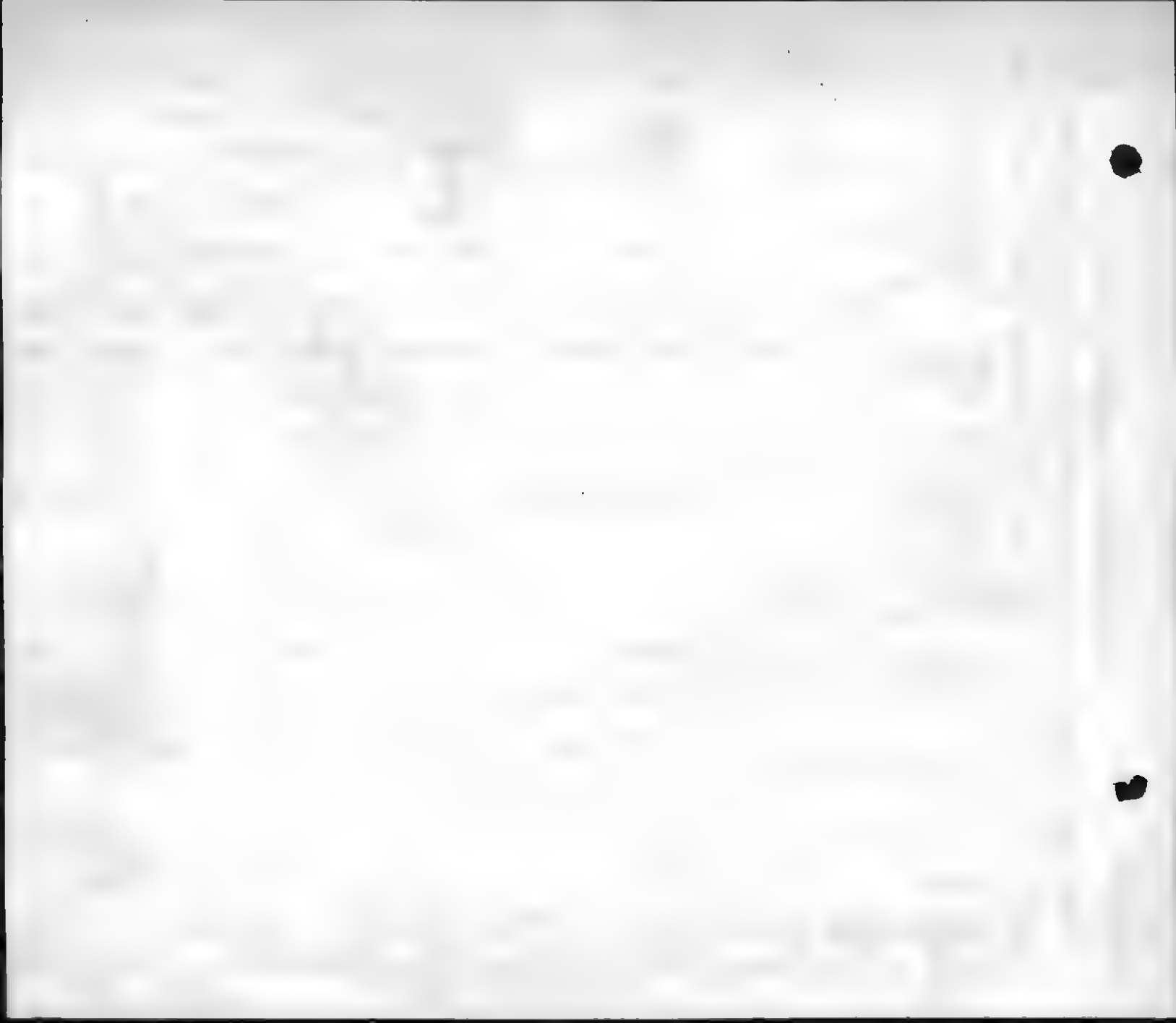
25. FUNERAL DIRECTOR

ADDRESS

1217 St. Paul Street

THIS IS A PERMANENT RECORD. PLEASE TYPE RITE WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. The Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and leg. HIS CERTIFICATE MUST FILED WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

MEDICAL CERTIFICATION



02349

MARYLAND

STATE DEPARTMENT OF HEALTH

2372

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and OR TOWN <u>CATONSVILLE</u> )		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTO.</u> <u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RECEDE KNOLL</u>		STREET ADDRESS (If rural, give location) <u>4104 WALRAD AVE.</u>	
3. NAME OF DECEASED (First) <u>M.</u> (Middle) <u>ELIZABETH</u> (Last) <u>FORRESTER</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>6</u> (Year) <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>SEPT. 11, 1873</u>
9. AGE last birthday <u>81</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>WILLIAM KOESTER</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET DIETERS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Bernard Forrester - 4104 Walrad Ave.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>331X</u> <u>Cerebral Vascular Accident.</u>			<u>48 hrs.</u>
Antecedent cause(s) (b) <u>Hypertension</u>			<u>16 yrs.</u>
(c) <u>Chronic disease</u>			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death. <u>Recurrent &amp; Congestive heart failure</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March 4, 1953</u> , to <u>March 6, 1953</u> , that I last saw the deceased alive on <u>March 5, 1953</u> , and that death occurred at <u>5:30 P.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Nelson McKay</u>		ADDRESS <u>6014 EDWARDS AVE</u>	
DATE SIGNED <u>3/8/55</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Interment</u>		DATE <u>3-9-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cms.</u>		LOCATION (City, town, or county) <u>Brooklyn Ind.</u>	
DATE REC'D BY LOCAL REG. <u>3-9-55</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Funeral Home - Catonsville, Md.</u>	

MARGIN RESERVED FOR BINDING

3 A DENTED



2373 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY	
CITY (If outside corporate limits, write OR and give nearest town) <u>52 Catonsville</u>		RURAL LENGTH OF STAY (in this place) <u>9 MO.</u>		CITY (If outside corporate limits, write OR and give nearest town) <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Paradise Nursing Home</u>				STREET ADDRESS (If rural give location) <u>723 E. Belvedere Ave</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Rhoda</u> (Middle) <u>F.</u> (Last) <u>Fox</u>		4. DATE OF DEATH: (Month) <u>March</u> (Day) <u>2</u> (Year) <u>1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Oct 11 1872</u>	9. AGE last birthday: <u>82</u> yrs.	10. Months	11. Days	12. Hours
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>George W Green</u>				14. MOTHER'S MAIDEN NAME: <u>Theresa Duffy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY No: <u>-</u>		17. INFORMANT & ADDRESS: <u>Mrs Ida Brooks 723 E Belvedere Ave</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<u>450.0</u>		
Immediate cause (a) <u>Myocardial failure</u>		<u>72 hrs</u>
Antecedent causes (s) (b) <u>Arterio sclerosis, generalized, severe</u>		<u>Unknown</u>
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Unknown</u>		

11. OTHER SIGNIFICANT CONDITIONS		20. AUTOPSY?	
Conditions contributing to the death but not related to the disease or condition causing death.		Yes <input type="checkbox"/> No <input type="checkbox"/>	
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
SUICIDE	INJURY		
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED	HOW DID INJURY OCCUR?	
OF INJURY	While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		

22. I hereby certify that I attended the deceased from 1-17, 1955, to 3-2, 1955, that I last saw the deceased alive on 3-1, 1955, and that death occurred at 7:30 AM, from the causes and on the date stated above.

SIGNATURE <u>Stephen Lee M.D.</u> (Degree or title)		ADDRESS <u>Catonsville, Md</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF <u>Mar 5-55</u>	NAME OF CEMETERY OR CREMATORY <u>St Marys (Catholics)</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>
DATE REC'D BY LOCAL REGISTRAR <u>3-3-55</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Burke's Funeral Home</u>	ADDRESS <u>3631 Falls Rd</u>
		by <u>Nurse [Signature]</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2374

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1 PLACE OF DEATH:				2 USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Sparrows Point				OR TOWN Sparrows Point X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1316 Forrest Road				STREET ADDRESS (If rural give location) 1316 Forrest Road			
3. NAME OF DECEASED: (First) FRED (Middle) RAYMOND (Last) FOY, SR.				4. DATE OF DEATH: (Month) March 5, (Day) 1955 (Year) 19			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: March 28, 1906	
				9. AGE last birthday: 48 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Burner				10b. KIND OF BUSINESS OR INDUSTRY: Shipyard		11. BIRTHPLACE (State or foreign country): Penna.	
13. FATHER'S NAME: John W. Foy				14. MOTHER'S MAIDEN NAME: Emma G. McCracklin			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No.		16. SOCIAL SECURITY No.: (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: Mrs. Virgie M. Foy 1316 Forrest Road-19			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
157X Immediate cause (a) Generalized Carcinomatosis DUE TO							
Antecedent causes (s) (b) Carcinoma of Head of Pancreas DUE TO							
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 10, 1954, to Mar. 5, 1955, that I last saw the deceased alive on Mar. 5, 1955, and that death occurred at 5:00 P.M., from the causes and on the date stated above.							
SIGNATURE James P. Mcena		(Degree or title) M.D.		ADDRESS 520 D St		DATE SIGNED 3/7/55	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF March 8, 1955		NAME OF CEMETERY OR CREMATORY Oak Lawn		LOCATION (City, town, or county) Volgate, Md.	
DATE REC'D BY LOCAL REGISTRAR 3-8-55		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR Ullrich Funeral Home		ADDRESS 2112 Dundalk Ave.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND

2375

STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>MARYLAND</b> COUNTY <b>BALTO.</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <b>RANDALLSTOWN-</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>RANDALLSTOWN-</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MARRIOTT SUITE ROAD</b>		STREET ADDRESS (If rural, give location) <b>MARRIOTT SUITE ROAD -</b>	
3. NAME OF DECEASED (Type or Print) <b>RICHARD PETER GANJON</b>		4. DATE OF DEATH <b>MARCH 24 1955</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <b>FEB 10-1903</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BOOK-BINDER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BOOK-BINDER</b>	
11. BIRTHPLACE (State or foreign country) <b>ESSEN - GERMANY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>GEORGE L. GANJON</b>		14. MOTHER'S MAIDEN NAME <b>EMILIE OPITZ</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If year, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT, AND ADDRESS <b>MRS HATTIE E. GANJON - RANDALLSTOWN MD</b>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <b>CARCINOMA OF STOMACH</b>			<b>18 MONTHS</b>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <b>MAY 7-1954</b>	19b. MAJOR FINDINGS OF OPERATION <b>CARCINOMA OF STOMACH - GASTRO-ENTEROSTOMY -</b>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **JUNE 1, 1953**, to **MARCH 24, 1955**, that I last saw the deceased

on **MARCH 24, 1955**, and that death occurred at **2:15 P.M.**, from the causes and on the date stated above.  
SIGNATURE **Thomas E. Wheeler MD** ADDRESS **Randallstown, Md.** DATE SIGNED **3-24-55**

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE <b>3-26-55</b>	NAME OF CEMETERY OR CREMATORY <b>Ward's Chapel Cemetery</b>	LOCATION (City, town, or county) (State) <b>Baltimore Co. Md.</b>
DATE REC'D BY LOCAL REG. <b>3/25/55</b>	REGISTRAR'S SIGNATURE <b>Thos. E. Wheeler</b>	24. FUNERAL DIRECTOR <b>Ellsworth Armacost</b>	

Ellsworth Armacost 4600 Liberty Heights Ave

8 3 1000000

2376

CERTIFICATE OF DEATH

Reg. Dist. No. *21*

1 PLACE OF DEATH:		2 USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Balto.</i>	MARYLAND	STATE <i>Md</i>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Woodlawn</i>	LENGTH OF STAY (in this place) <i>14 yrs.</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Woodlawn</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Jacobsburg Home</i>		STREET ADDRESS (If rural give location) <i>6811 Campfield Rd</i>	
3. NAME OF DECEASED: (Type or Print) <i>Sauline</i> (First) (Middle) (Last) <i>Block.</i>		4. DATE OF DEATH: <i>Mar. 26</i> (Day) (Year) <i>1955</i>	
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH: <i>May 26, 1871</i>
9. AGE last birthday: <i>83</i> yrs.		10. AGE last birthday: IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>None</i>	
11. BIRTHPLACE (State or foreign country): <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.</i>	
13. FATHER'S NAME: <i>Unknown</i>		14. MOTHER'S MAIDEN NAME: <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk) <i>No</i>		16. SOCIAL SECURITY No.: <i>W.</i>	
17. INFORMANT & ADDRESS: <i>Records Jacobsburg Home</i>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			Interval Between Onset and Death
Immediate cause (a) <i>(1) Anterior - Sclerotic Heart Disease</i>			<i>15 yrs.</i>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <i>with - Hypertension</i>			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>- Generalized Anterior - Sclerotic</i>			<i>10 yrs.</i>
19a. DATE OF OPERATION: <i>None</i>			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>Dec. 18, 1940</i> , to <i>Mar 26, 1955</i> , that I last saw the deceased alive on <i>Mar 24, 1955</i> , and that death occurred at <i>5:45 A.M.</i> , from the causes and on the date stated above.			
SIGNATURE <i>Earl J. Chambers</i>		DATE SIGNED <i>7 Mar 3 36 55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		DATE THEREOF <i>3 28 55</i>	NAME OF CEMETERY OR CREMATORY <i>FORT LINCOLN, WASH. D.C.</i>
DATE REC'D BY LOCAL REGISTRAR <i>March 26 1955</i>		REGISTRAR'S SIGNATURE <i>R.W.</i>	24. FUNERAL DIRECTOR <i>Earl J. Chambers</i>
		ADDRESS <i>6062 1/2 Fayard Rd</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

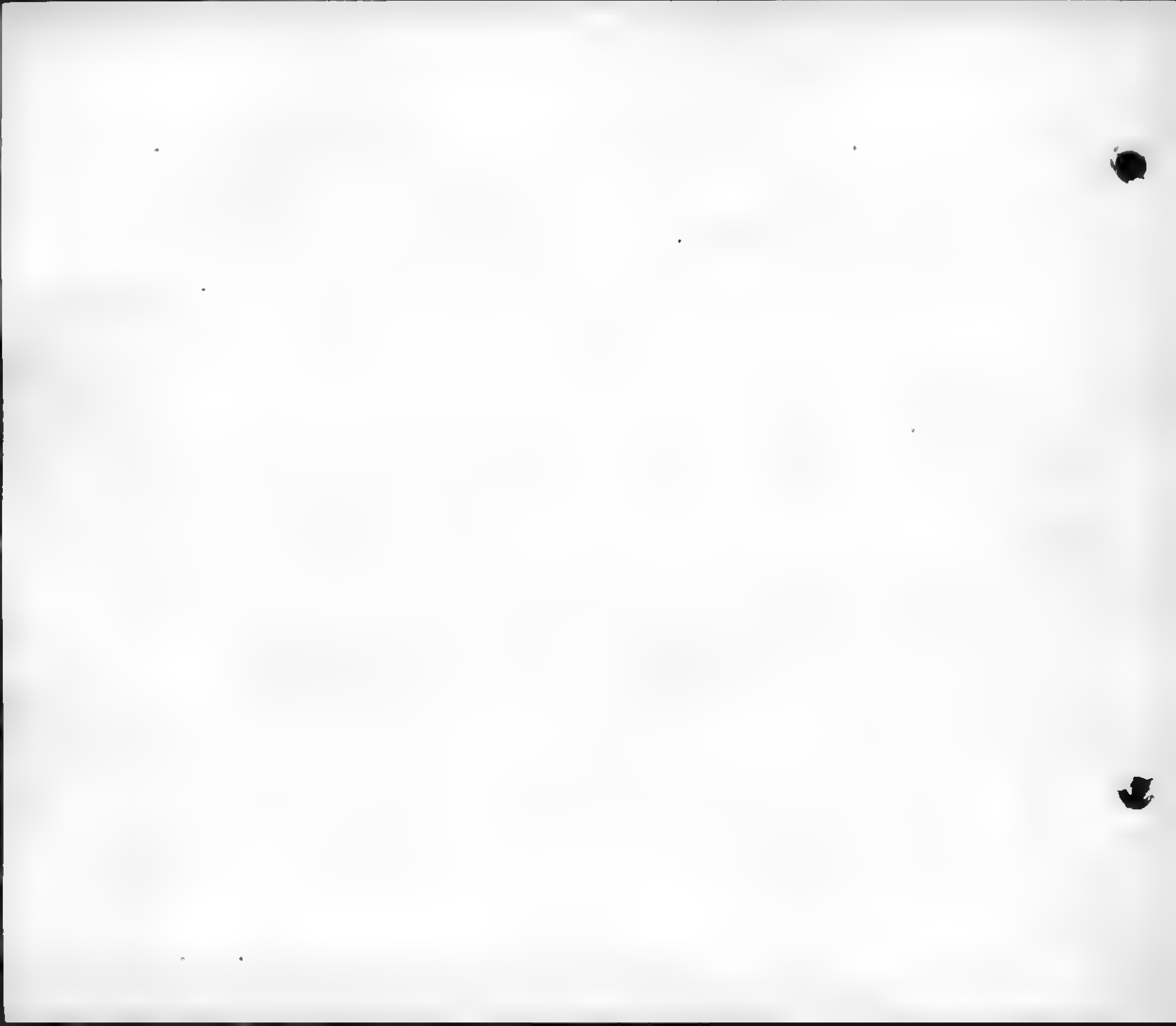
02354

2377

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH COUNTY <u>Balto.</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> OR TOWN <u>Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in the Pines 16 Fusting Ave.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> STREET ADDRESS (If rural give location) <u>914 Belgian Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>JENNIE MULHERN GRIFFITH</u> (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH: <u>Mar. 14 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>Aug. 25, 1884</u>	
9. AGE last birthday: <u>70</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME: <u>James P. Mulhern</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Hafferty</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT & ADDRESS: <u>Mr. Alfred Griffith - 352 Westshire Rd.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>GENERALIZED ARTERIOSCLEROSIS</u>						<u>10 YRS</u>	
ANTECEDENT CAUSE (B) <u>CHRONIC GLOMERULONEPHRITIS</u>						<u>46 YRS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>SPIENOMEGALIA</u>						<u>1 YRS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CEREBRO-VASCULAR ACCIDENT</u>						<u>1 YR</u>	
19A. DATE OF OPERATION: <u></u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/3, 1953</u> , to <u>3/13, 1955</u> , that I last saw the deceased alive on <u>12/3, 1953</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>James R. Skylesian</u> ADDRESS <u>2212 South Road Baltimore, Md.</u> DATE SIGNED <u>4/3/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Cremation</u>		<u>3/16/55</u>		<u>Loudon Park Crematory</u>		<u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-16-55</u>		REGISTRAR'S SIGNATURE <u>W. H. Hedden</u>		24. FUNERAL DIRECTOR <u>Wm. J. Pickens</u>		ADDRESS <u>Louis Keith</u>	



2378

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Parkville</u>	
<u>X</u> TOWN <u>Parkville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2902 Onyx Road #14</u>		STREET ADDRESS (If rural give location) <u>2902 Onyx Road #14</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>Mr. Strother E. Grim</u>		<u>March 11 1955</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>March 7-1900</u>
9. AGE last birthday <u>55</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Winchester, Virginia</u>	11. CITIZEN OF WHAT COUNTRY? <u>USA</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Gas Fitter</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Gas &amp; Elec. Co.</u>	
13. FATHER'S NAME: <u>Mr. Samuel Grim</u>		14. MOTHER'S MAIDEN NAME: <u>Emily Sherman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-05-3914</u>	
		17. INFORMANT & ADDRESS: <u>Mrs. Alice E. Grim, 2902 Onyx Road #14</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Carcinoma of Pharynx</u>			<u>3 yrs.</u>
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb 1, 1955</u> , to <u>Mar 11, 1955</u> , that I last saw the deceased alive on <u>Mar 6, 1955</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Bronx Quacken</u>		ADDRESS <u>4808 Harford Rd.</u>	DATE SIGNED <u>3/12/55</u>
M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Mar. 14-1955</u>	<u>Moreland Memorial Park</u>	<u>Baltimore Maryland</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
	<u>Leonard J. Ruck</u>	<u>Leonard J. Ruck</u>	<u>5305 Harford Road #14</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Sawyer  
4808 Harford Road

Please Call us when completed. HA 6 1460  
Ruck Funeral Home.

2379

CERTIFICATE OF DEATH

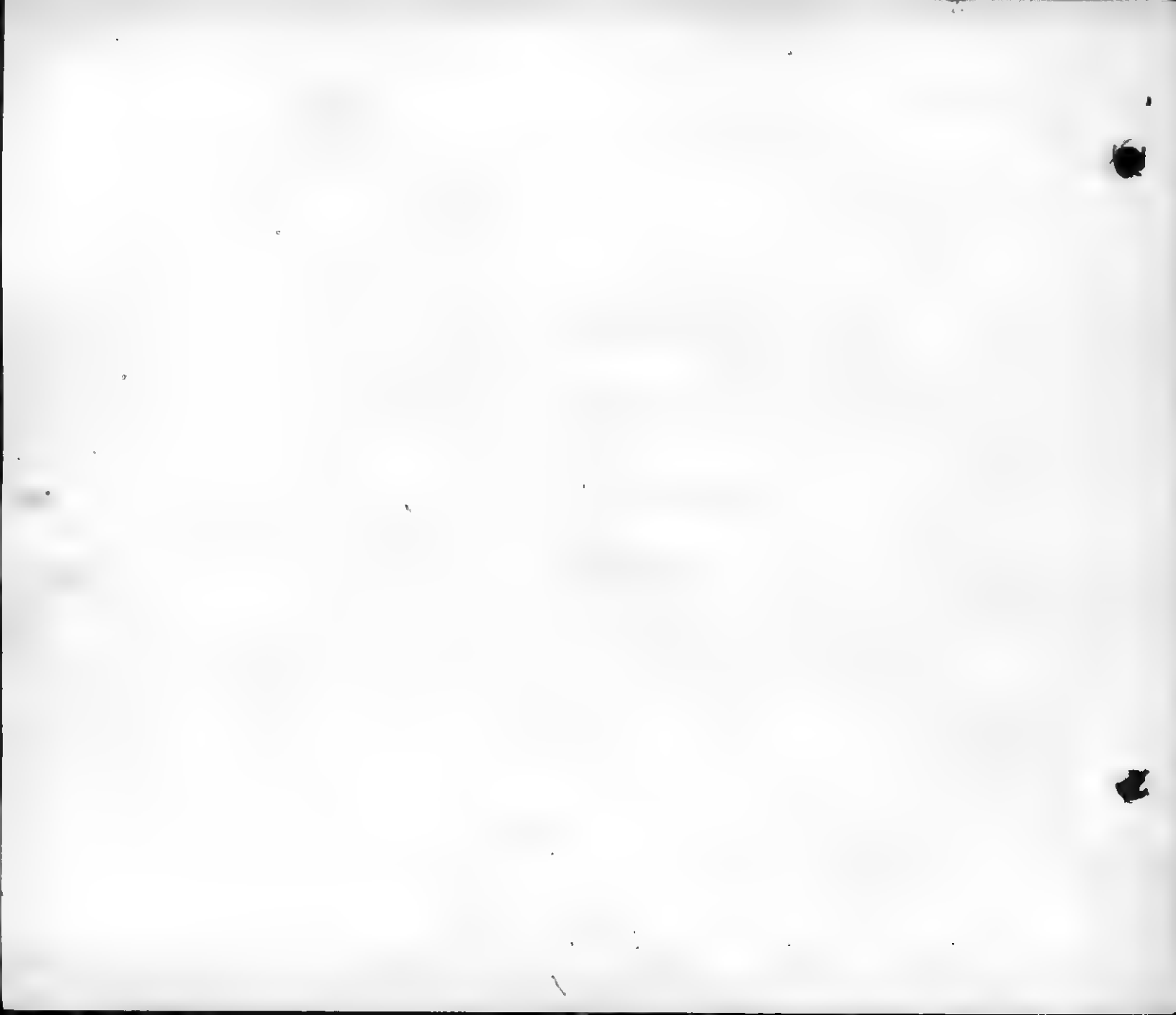
Reg. Dist. No.

Item 14, Film 178 3-17-55 et

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Baltimore</b>	MARYLAND	STATE <b>Md</b>	COUNTY <b>Baltimore</b>
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	52
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <b>16 Jones Ave.</b>	
3. NAME OF DECEASED: (First) (Middle) (Last) <b>Charles Gross</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>3-10-55</b> 19	
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>	8. DATE OF BIRTH:
		9. AGE last birthday: <b>76</b> yrs.	IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <b>Maryland</b>
13. FATHER'S NAME: <b>William Gross</b>		14. MOTHER'S MAIDEN NAME: <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS: <b>Mrs. Marv Gross 16 Jones Ave.</b>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
331X IMMEDIATE CAUSE (A) <b>Cerebral Hemorrhage</b>			4 days
ANTECEDENT CAUSE (B) <b>Hypertensive Arterio-sclerosis</b>			10 mo-29
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>4-15-1954</b> to <b>3-10-1955</b> that I last saw the deceased alive on <b>3-10-1955</b> , and that death occurred at <b>1 A M.</b> from the causes and on the date stated above.			
SIGNATURE <b>C. J. Maloney</b>		DATE SIGNED <b>3-10-55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>3-14-55</b>	
NAME OF CEMETERY OR CREMATORY <b>Western Star</b>		LOCATION (City, town, or county) (State) <b>Catonsville Md</b>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS <b>5784</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

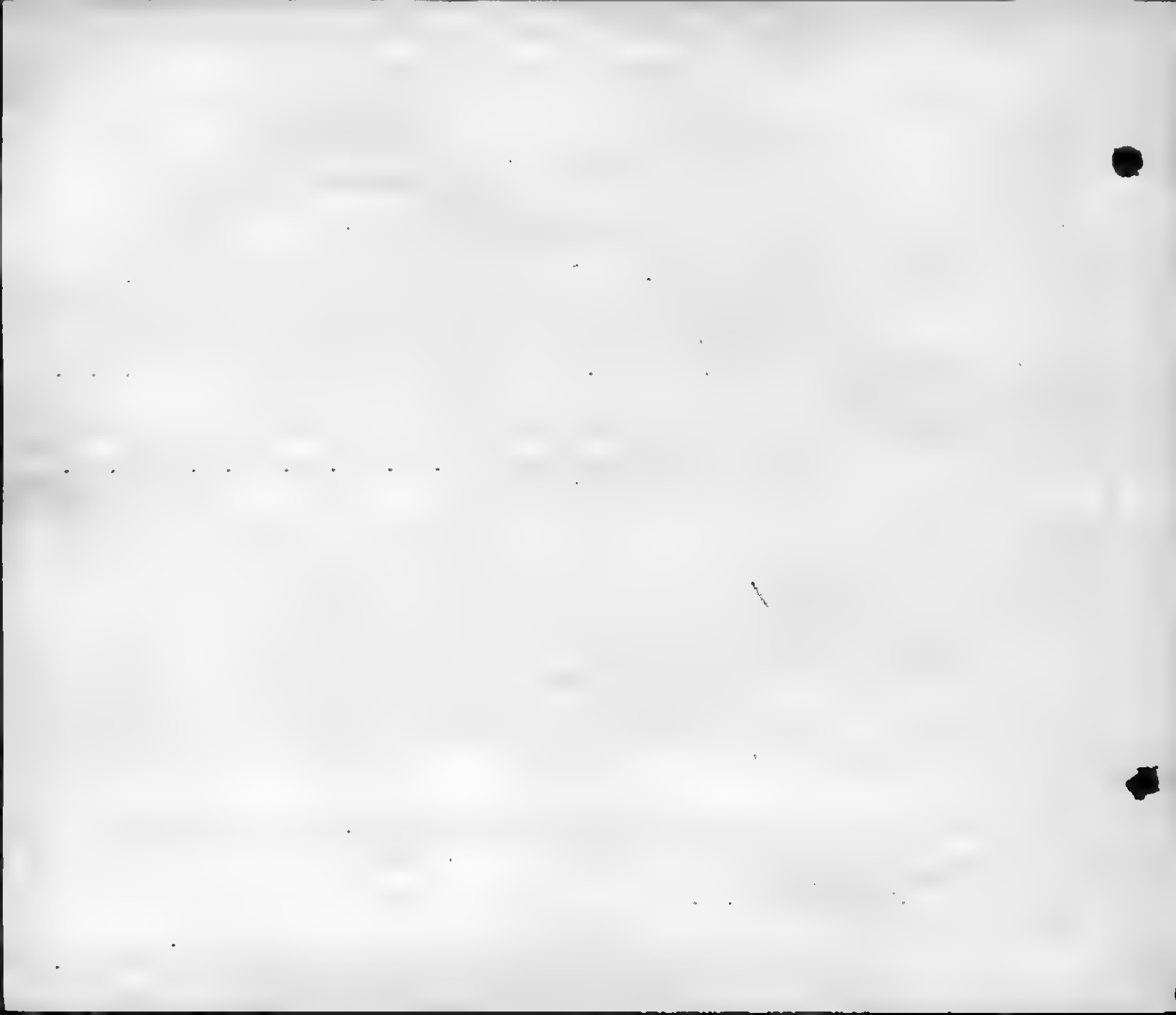


PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02357  
2380  
CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>20 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>606 S. Smallwood Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>HARRY M. HALL</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>March 23, 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH: <u>July 9, 1889</u>	9. AGE last birthday <u>65</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attendant</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>B. &amp; O. R. R.</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Jefferson Hall</u>				14. MOTHER'S MAIDEN NAME: <u>Florenz M. Shewbridge</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>705-05-5890</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp. Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CARCINOMA OF RIGHT LUNG</u>						UNKNOWN	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that <del>K</del> attended the deceased from <u>March 3, 1955</u> , to <u>Mar. 23, 1955</u> , and that death occurred at <u>9:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William B. VandeGrift, M.D.</u>		DATE THEREOF <u>3-23-55</u>		NAME OF CEMETERY OR CREMATORY <u>Louden Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-23-55</u>		NAME OF CEMETERY OR CREMATORY <u>Louden Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-24-55</u>		REGISTRAR'S SIGNATURE <u>A. W. [Signature]</u>		24. FUNERAL DIRECTOR <u>Wm. Ticker, North &amp; Pennsylvania Aves.</u>		ADDRESS <u>Baltimore, Md.</u>	





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2381

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02358  
Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND <u>md</u>	STATE <u>md</u>	COUNTY <u>Balto</u> <input checked="" type="checkbox"/>
CITY (If outside corporate limits, write RURAL OR <u>and give nearest town</u> ) <u>X</u> TOWN <u>Balto 20, Md. Rm.</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Balto 20, Middle Rm.</u>	
HOSPITAL OR INSTITUTION OR STREET <u>Adriano Suspectana Ave</u>		STREET ADDRESS (If rural, give location) <u>18499 Rk. 15. Suspectana's</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(Type or Print) <u>Ellen Antoinette Hamper</u>		(Month) (Day) (Year) <u>Mar 29 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Feb 7, 1898</u>
9. AGE last birthday: <u>57</u> yrs.		10. IF UNDER 1 YEAR: <u>1</u> Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min.	
11. BIRTHPLACE (State or foreign country): <u>Baltimore City.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>John Benda</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Benda</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>219-10-0395</u>	
17. INFORMANT & ADDRESS: <u>John T. Hamper (Husband)</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) ... <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) ... <u>Chronic Alcoholism</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) ...		<u>Immediate</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
21c. (City or town) (County) (State)		21d. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY: <u>Dec 3-29 55 3A</u> M.	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE: <u>Wm. J. Hamper M.D.</u>		DATE SIGNED: <u>Mar 29 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>4-1-55</u>	
NAME OF CEMETERY OR CREMATORY: <u>Grand View</u>		LOCATION (City, town, or county) (State): <u>German Hill Rd. Md.</u>	
DATE REC'D BY LOCAL REG. <u>3-30-55</u>		REGISTRAR'S SIGNATURE: <u>G. W. ...</u>	
24. FUNERAL DIRECTOR: <u>...</u>		ADDRESS: <u>...</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# 2382

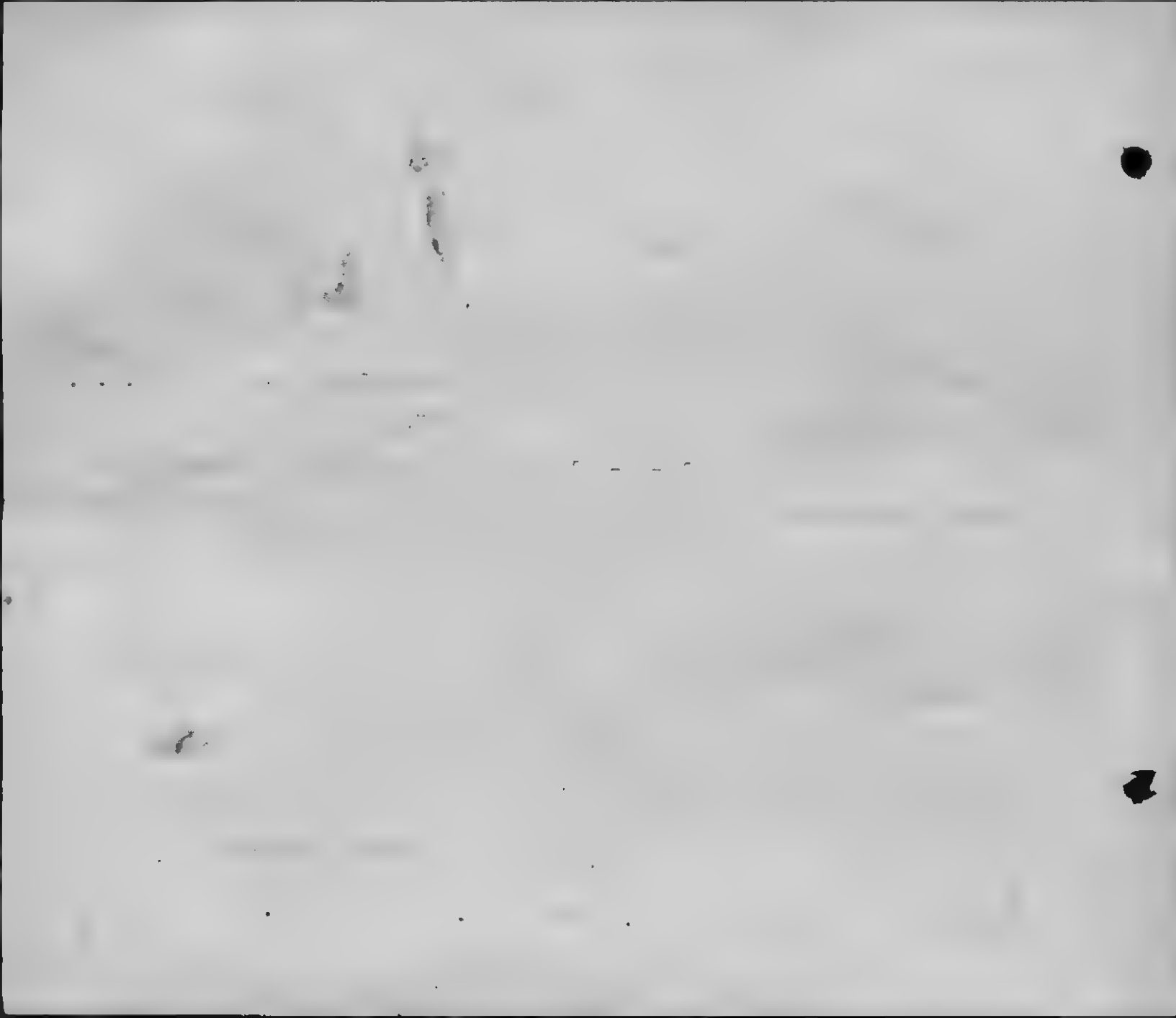
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02359  
Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>Md.</u>	COUNTY
CITY (If outside corporate limits write RURAL and give nearest town) <u>TOWNSHIP Sparrow Point</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Baltimore 16</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Shipyard St. Dept. Berk. Steel Co.</u>		STREET ADDRESS <u>2823 Baker St.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Henry</u> (Middle) <u>L.</u> (Last) <u>Harden</u>		(Month) <u>Mar</u> (Day) <u>25</u> (Year) <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Married</u>	8. DATE OF BIRTH: <u>Aug 2 1904</u>
9a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Shipper</u>		9b. AGE last birthday: <u>50</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Shipper</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Berk. Steel Co.</u>	
11. BIRTHPLACE (State or foreign country): <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>HENRY HARDEN</u>		14. MOTHER'S MAIDEN NAME: <u>JENNIE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No.: <u>213-07-0912</u>	
17. INFORMANT & ADDRESS: <u>ROXIE HARDEN (W) 2823 BAKER ST.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary occlusion</u>		DUE TO		<u>Immediate</u>	
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last</u>		DUE TO			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg, etc.) OF INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>Nov 3-15-55 2:30 P.M.</u>		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE: <u>St. Clair M.D.</u>		M. D.		DEPUTY MEDICAL EXAMINER: <u>Charles H. Harper</u> DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF: <u>3/28/55</u>		NAME OF CEMETERY OR CREMATORY: <u>MT. AUBURN CEM.</u>	
LOCATION (City, town, or county) (State): <u>BALTO. MD</u>		24. FUNERAL DIRECTOR: <u>Charles H. Harper</u>		ADDRESS: <u>512 Cambridge Ave.</u>	



MARYLAND

2383

02360

STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Glenn Falls Road</b>		STREET ADDRESS (If rural, give location) <b>Glenn Falls Road</b>	
3. NAME OF DECEASED (Type or Print) <b>George W. Harris</b>		4. DATE OF DEATH <b>March 26, 1955</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWER, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Nov. 27, 1879</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employed by Balto. County Roads</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <b>75</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Baltimore County</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George Harris</b>		14. MOTHER'S MAIDEN NAME <b>Alice</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <b>Bernard Uhler, Reisterstown, Md.</b>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <b>Generalized Carcinomatosis</b>			<b>7 mo.</b>
Antecedent cause(s) (b) <b>Carcinoma of Stomach</b>			<b>1 yr.</b>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>9 schiv. Rectal Abscess</b>			<b>7 mo.</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <b>Aug 54</b>	19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma of Stomach (Repyloric)</b>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>None</b>	PLACE (Home, farm, factory, street, office bldg., etc.) <b>None</b>	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>None</b>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <b>None</b>	

22. I hereby certify that I attended the deceased from **8-13**, 19**54**, to **3-26**, 19**55**, that I last saw the deceased

alive on **3-15**, 19**55**, and that death occurred at **5:30 P.M.**, from the causes and on the date stated above.

SIGNATURE **D. D. Caples** (Degree or title) **M.D.** ADDRESS **Reisterstown Md.** DATE SIGNED **3-28-55**

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE <b>Mar. 29, 1955</b>	NAME OF CEMETERY OR CREMATORY <b>St. Paul</b>	LOCATION (City, town, or county) <b>Baltimore County</b>
DATE REC'D BY LOCAL REG. <b>3-29-55</b>	REGISTRAR'S SIGNATURE <b>Mary B. Zline</b>	24. FUNERAL DIRECTOR ADDRESS <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>	

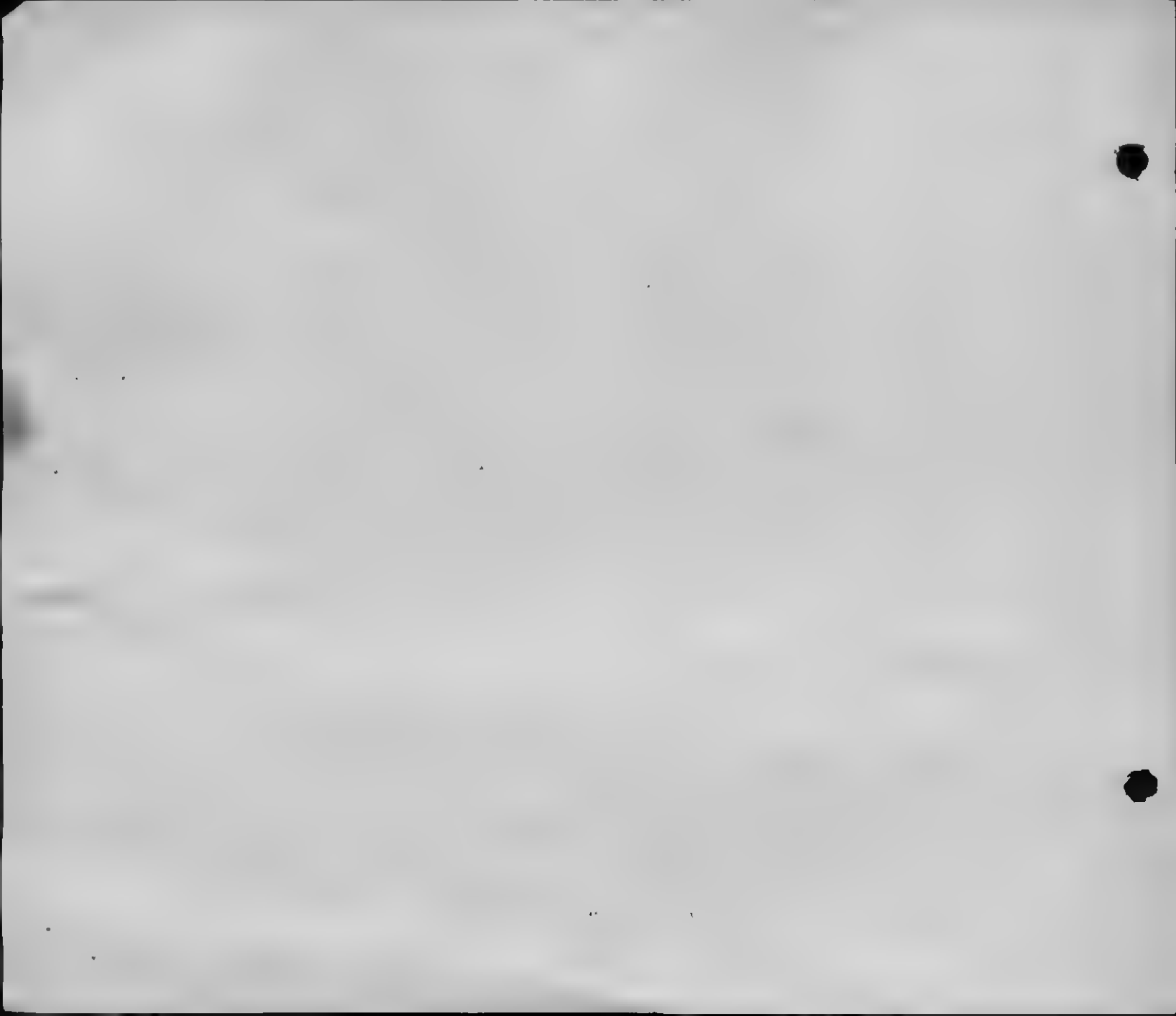
MARGIN RESERVED FOR BINDING

JOHN A. S.

1911

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

22847, P.L. 3178 3-17-55 at				02361			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Md.		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN			
X TOWN Balto.		Life		TOWN Baltimore X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS at home				STREET ADDRESS (If rural, give location) Box 626 Bird River Rd. /			
3. NAME OF DECEASED: (First) RAYMOND		(Middle) W. (or William Raymond) HARRIS		4. DATE OF DEATH		(Month) (Day) (Year) March 10, 1955	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: May 10, 1908	9. AGE last birthday: 46 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY: Electrical Contractor		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Wm. J Harris				14. MOTHER'S MAIDEN NAME: Florence Bevans			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: 219-20-9371		17. INFORMANT & ADDRESS: Mrs. R.W. Harris 626 Bird River Rd. Balto. 20			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH:	
4-5-55 Immediate cause (a)..... Coronary occlusion with former myocardial infarction							
Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c).....							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		R. B. Fisher		M.D.		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM. DATE SIGNED 3/10/55	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF March 13/55		NAME OF CEMETERY OR CREMATORY E. Ebenzer		LOCATION (City, town, or county) (State) Balto. Md.	
DATE REC'D BY LOCAL REG. 3-12-55		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS Lassahn Funeral Home 7401 Belair Rd. 6	





MARYLAND STATE DEPARTMENT OF HEALTH

02362

2385

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Balt</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Sparks Pt</u> LENGTH OF STAY (in this place) <u>25 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sparks Pt</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>707 2d St</u>		STREET ADDRESS (If rural, give location) <u>707 2d St</u>	
3. NAME OF DECEASED (First) <u>Fredrick</u> (Middle) <u>Hebron</u> (Last) <u>Hebron</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>12</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>7-1-87</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hebron</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Mills</u>	9. AGE last birthday <u>67</u> yrs. If under 1 year If under 24 hrs. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Sam'l Hebron</u>		14. MOTHER'S MAIDEN NAME <u>Catherine?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mary J. Hebron - 707 2d St Sparks Pt</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause	(a) <u>Virus Pneumonia</u>			<u>10 days</u>
Antecedent cause(s)	(b) <u>Hypertension - Arteriosclerosis</u>			<u>unknown</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work Not While At work		HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from October 1954, to March 12, 1955, that I last saw the deceased alive on March 12, 1955, and that death occurred at 11:50 A.M. from the causes and on the date stated above.

SIGNATURE <u>W. E. Thomas MD.</u>		ADDRESS <u>107 N. Main St Baltimore 22 Md</u>		DATE SIGNED <u>3/12/55</u>	
23. BURIAL (Cremation Removal) (Specify) <u>Burial</u>		DATE <u>3-17-55</u>		NAME OF CEMETERY OR CREMATORY <u>Catholics</u>	
LOCATION (City, town, or county) <u>Baltimore Md</u>		(State) <u>Md</u>			
DATE REC'D BY LOCAL REG. <u>3-15-55</u>		REGISTRAR'S SIGNATURE <u>A. W. Pedrick</u>		24. FUNERAL DIRECTOR <u>Samuel W. Sullivan Jr</u>	
				ADDRESS <u>1011 27. Arlington Ave Baltimore</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2314

MARYLAND STATE DEPARTMENT OF HEALTH

02363

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

Item. . . . . Film 6179 3-28-55 et

1. PLACE OF DEATH COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>And.</u>	
53 CITY (If outside corporate limits, write RURAL and give nearest town) <u>Gray Manor Brundall</u>		53 CITY (If outside corporate limits, write RURAL and give nearest town) <u>Gray Manor</u>	
60 TOWN <u>Gray Manor</u>		STREET ADDRESS <u>2704 McComas Ave</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2704 McComas Ave</u>		(If rural, give location)	
3. NAME OF DECEASED (First) <u>Charlotte</u> (Middle) <u>Elizabeth</u> (Last) <u>Herget</u>		4. DATE OF DEATH (Month) <u>Mar</u> (Day) <u>15</u> (Year) <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Sept 7. 64</u>
9. AGE last birthday <u>90</u> yrs.		10. AGE last birthday (If under 1 year) Months <u>11</u> Days <u>15</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>Sottie Becker</u>		1531 W. Balto St.	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>CORONARY Embolism</u>			<u>1 HOUR</u>
Antecedent cause(s) (b) <u>HYPERTENSION</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>ARTERIO-SCLEROSIS - Senile dementia.</u>			
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death. <u>VASCULAR changes</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office hldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>March 15</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>March 15</u> , 19 <u>55</u> , and that death occurred at <u>1:50 p.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Morris G. Jacob</u>		ADDRESS <u>1010 North Brent Rd.</u>	
DATE SIGNED <u>3/16/55</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/18/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u>		LOCATION (City, town, or county) <u>Balto md</u>	
DATE REC'D BY LOCAL REG. <u>3-17-55</u>		REGISTRAR'S SIGNATURE <u>Paul Heilmann</u>	
24. FUNERAL DIRECTOR <u>Paul Heilmann</u>		ADDRESS <u>6067 Harford Rd</u>	

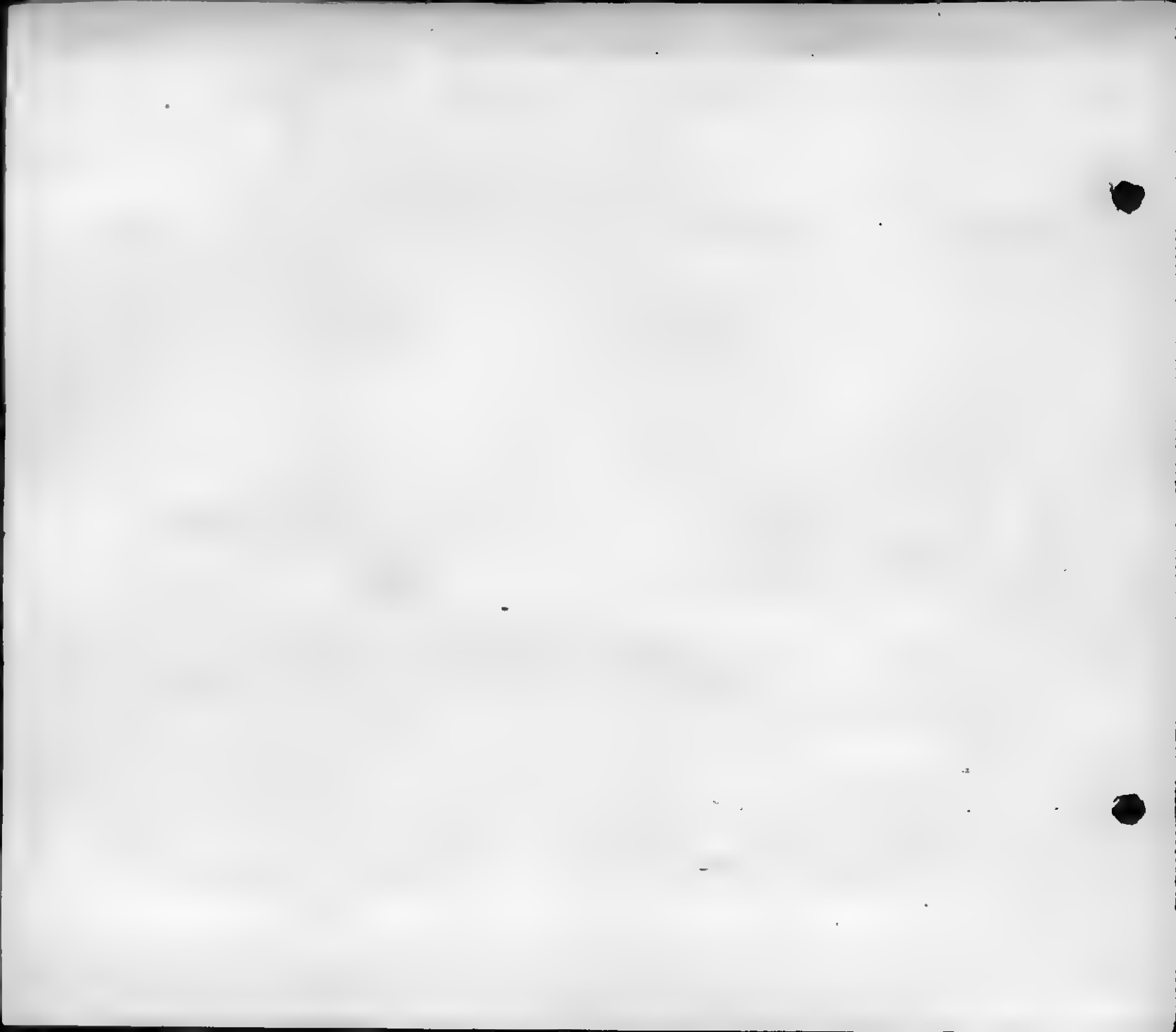


MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH				Registered No.
1. NAME OF DECEASED (Type or Print)		WILLIAM JOSEPH HOUCK		2. DATE OF DEATH 3/22/55
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD COUNTY BALTO.		
B. FULL NAME OF HOSPITAL OR INSTITUTION 55 21 REGESTER AVE		C. CITY OR TOWN TOWSON 55		
C. Length of stay in Baltimore LIFE		D. STREET ADDRESS (If rural, give location) 21 REGESTER AVE.		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In year, last birthday)
1	W	MARRIED	SEPT. 18, 1904	50
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
INVESTOR OPERATOR		MOVIE		BALTO., MD.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
JOHN R. HOUCK		MARY E. LEBER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT
		213-01-2213		ANNA K. HOUCK
18. 196X		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		SARCOMA, LEFT FEMUR		3/19/55
ANTECEDENT CAUSES		GENERALIZED METASTASIS		10/54
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				
II		AMPUTATION LEFT LEG - SARCOMA		3/19/55
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY?
3/29/55		SARCOMA		YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
		BUSINESS		HARFORD THEATRE (BALTIMORE)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
12 29 1950				Struck leg in metal object
22. I hereby certify that I attended the deceased from 10/20/54, 19, to 3/22/55, 19, that I last saw the deceased alive on 3/21/55, 19, and that death occurred at 8 P. M., from the causes and on the date stated above.				
23A. SIGNATURE		23B. ADDRESS		23C. DATE SIGNED
H. J. Jenkins		4331 Harford Rd		3/22/55
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY
BURIAL		3 26 - 1955		HOLY REDEEMER
24D. LOCATION (City, town, or county)		24E. LOCATION (City, town, or county)		MD
24D. LOCATION (City, town, or county)		24E. LOCATION (City, town, or county)		MD
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR
3-24-55		A. H. Jenkins		H. J. Jenkins & Sons Co. 4-105 York Rd.



2387

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>SAME</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>EDGEWATER (19)</u>		<u>13 YRS</u>		OR TOWN		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2628 BRANNON AVE.</u>				STREET ADDRESS <u>#1</u> (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH:			
(First) <u>FLORENCE</u> (Middle) <u>EDNA</u> (Last) <u>HOUTZ</u>				(Month) <u>3</u> (Day) <u>6</u> (Year) <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS		
<u>F.</u>	<u>W.</u>	<u>MARRIED</u>	<u>DEC. 24, 1888</u>	<u>66</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>PENNA</u>	
13. FATHER'S NAME: <u>NATHANIEL RECHTEL</u>				14. MOTHER'S MAIDEN NAME: <u>ELIZABETH CULVEY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No.: <u>194-12-6032</u>		17. INFORMANT & ADDRESS: <u>JOHN E. HOUTZ - 2628 BRANNON AVE.</u>	

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
<u>475.0</u>					
Immediate cause (a) <u>Acute Coronary Insufficiency</u>					
DUE TO					
Antecedent causes (s) (b) <u>Arteriosclerotic Heart Disease</u>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE SUSTAINING THE UNDERLYING CAUSE LAST. DUE TO					
(c)					
11. OTHER SIGNIFICANT CONDITIONS					
Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
SUICIDE		INJURY			
HOMICIDE					
TIME (Month) (Day) (Year) (Hour) (Minute)		INJURY OCCURRED		HOW DID INJURY OCCUR?	
OF INJURY		While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>54</u> , to <u>Mar 6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Mar 6</u> , 19 <u>55</u> , and that death occurred at <u>9:10 A.M.</u> , from the causes and on the date stated above.					
SIGNATURE		(Degree or title)		DATE SIGNED	
<u>James T. Means</u>		<u>M.D.</u>		<u>3/6/55</u>	
ADDRESS					
<u>520 E. St. East. 15 Ind</u>					
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>		<u>3-9-55</u>		<u>LUTHERAN &amp; REFORM</u>	
LOCATION (City, town, or county) (State)					
<u>ORWIN - PENNA</u>					
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
<u>March 8-55</u>		<u>Dawson L. Harbor</u>		<u>Walter Burke Bradley, Wendell, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5-2-2

BUREAU OF

10 1955





2388

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1 PLACE OF DEATH:				2 USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 TOWN Catonsville		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore		5-1-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 70 Paradise Nursing Home				STREET ADDRESS (If rural give location) 6816 Gough St.			
3. NAME OF DECEASED: (First) EDWARD		(Middle) A.		(Last) HOYT		4. DATE OF DEATH: March 23, 1955	
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: Aug. 21, 1891	
				9. AGE last birthday: 63 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Foreman				10b. KIND OF BUSINESS OR INDUSTRY: National Cab Co.		11. BIRTHPLACE (State or foreign country): Maryland	
13. FATHER'S NAME: ? Hoyt				14. MOTHER'S MAIDEN NAME: ?			
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No.				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Mrs. Margaret Haas 6816 Gough St.	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
421. Immediate cause (a) Myocardial failure							
Antecedent causes (s) (b) Mitral regurgitation							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) Arteriosclerosis CVD							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. ① Hemiplegia ② Parkinsonism							
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION							
Interval Between Onset And Death 72 hours							
20. AUTOPSY ? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9-29, 1954, to 3-23, 1955, that I last saw the deceased alive on 3-23, 1955, and that death occurred at 8:50 P.M., from the causes and on the date stated above.							
SIGNATURE Stephen J. Hargess M.D.				DATE SIGNED 3-25-55			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		March 26, 1955		Parkwood		Parkville, Md.	
DATE REC'D BY LOCAL REGISTRAR 3-26-55		REGISTRAR'S SIGNATURE T.E. Harry		24. FUNERAL DIRECTOR		ADDRESS	
				Ullrich Funeral Home		4210 Belair Road.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 20 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02367

2389

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fort Howard</u> LENGTH OF STAY (in this place) <u>42 Days</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>11</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u> STREET ADDRESS (If rural give location) <u>206 Glen Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>HAROLD S. HUFFINGTON</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>March 28, 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>March 6, 1896</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Insurance</u>		11. BIRTHPLACE (State or foreign country): <u>Princess Anne, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Alexander J. Huffington</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Malone</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) <u>Yes</u> (If Yes, give war or dates of service) <u>WW-I</u>		16. SOCIAL SECURITY NO.: <u>212-03-5308</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Fort Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CEREBRAL HEMORRHAGE, RIGHT, IN METASTASES FROM CARCINOMA, RIGHT LUNG</u>						1 DAY	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb. 14, 1955, to Mar. 28, 1955, and that death occurred at 5:20 P.M., from the causes and on the date stated above.							
SIGNATURE <u>William B. Vandegriff, M. D.</u>				ADDRESS <u>M. D. VAN, Fort Howard, Md.</u> DATE SIGNED <u>3-29-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/31/55</u>		NAME OF CEMETERY OR CREMATORY <u>Manokin Cemetery</u>		LOCATION (City, town, or county) (State) <u>Princess Anne, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-31-55</u>		REGISTRAR'S SIGNATURE <u>Lawrence L. Fisher, Jr.</u>		24. FUNERAL DIRECTOR ADDRESS <u>Walter Holloway &amp; Company Salisbury, Maryland</u>			

STANDARD

APR 1

1944

2390

## CERTIFICATE OF DEATH

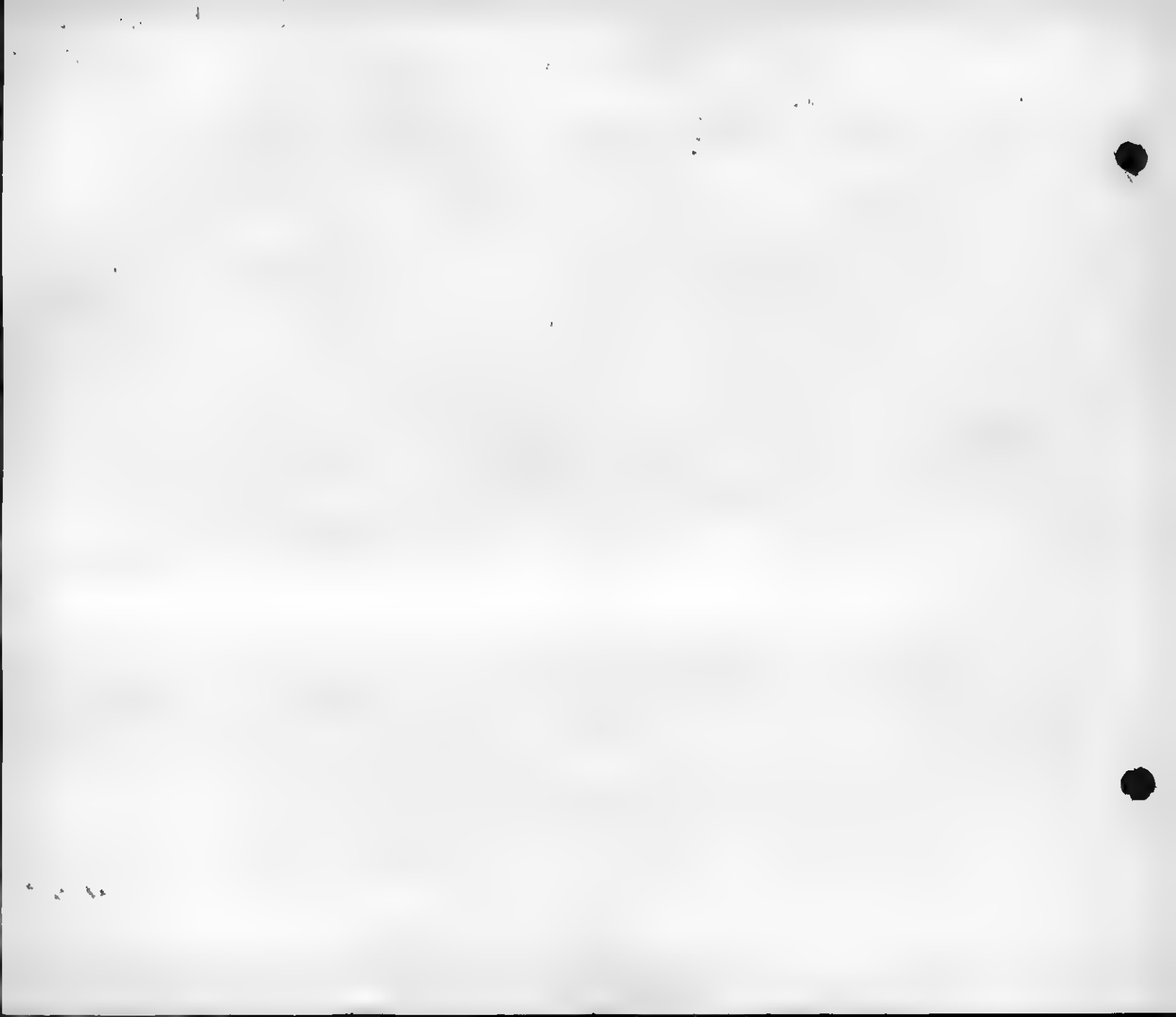
Reg. Dist. No.

30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>MD.</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	LENGTH OF STAY (in this place) <u>4 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>3701-4</u>
TOWN <u>Catonsville</u>		OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove Hosp.</u>		STREET ADDRESS (If rural give location) <u>1105 W 37th St</u>	
3. NAME OF DECEASED: (Type or Print) <u>Annie M. Humbert</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Mar 27 1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>W</u>	8. DATE OF BIRTH: <u>Jan 4 - 1927</u>
9. AGE last birthday: <u>28</u> yrs	10. MONTHS: <u>7</u>	11. DAYS: <u>8</u>	12. HOURS: <u>1</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>H.W.</u>	10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>William Goodingbell</u>	14. MOTHER'S MAIDEN NAME: <u>Maranda</u>	17. INFORMANT & ADDRESS: <u>Hospital Records</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>	16. SOCIAL SECURITY NO: <u>Not available</u>	18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE: <u>420.0</u>		<u>6 wks</u>	
ANTECEDENT CAUSE (S):		<u>1 year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Heart Failure</u>			
(B) <u>Arteriosclerotic Ht. Disease</u>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<u>Senile Psychosis</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec 7, 1951</u> , to <u>March 27, 1955</u> , that I last saw the deceased alive on <u>March 27, 1955</u> , and that death occurred at <u>12<sup>02</sup> P</u> M. from the causes and on the date stated above.			
SIGNATURE <u>Frederick E. Philp</u>		ADDRESS <u>Spring Grove Hosp</u>	
DATE SIGNED <u>March 30 - 1955</u>		DATE SIGNED <u>3/27/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's (Catholic)</u>	
LOCATION (City, town, or county) <u>Carroll Co., Md.</u>		24. FUNERAL DIRECTOR <u>Burgee Funeral Home</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-29-55</u>		REGISTRAR'S SIGNATURE <u>R. W. Hedrick</u>	
24. FUNERAL DIRECTOR <u>Burgee Funeral Home</u>		ADDRESS <u>3631 Falls Road</u>	
		Name <u>F. Burgee</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02369

2391

## CERTIFICATE OF DEATH

Reg. Dist. No. 47

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>FORT HOWARD</u>		<u>2 DAYS</u>		OR TOWN <u>BALTIMORE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>VETERANS ADMINISTRATION HOSPITAL</u>				<u>2854 RAYNER AVENUE</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>SYLVESTER W. HUNTER</u>				DEATH <u>MARCH 4 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
<u>MALE</u>	<u>COLORED</u>	<u>SINGLE</u>	<u>11-7-90</u>	<u>64</u> yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>HUCKSTER</u>				<u>BALTIMORE, MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>GEORGE HUNTER</u>				<u>SUSIE COTTMAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>YES</u> (If Yes, give war or dates of service) <u>WW I</u>		<u>UNKNOWN</u>		<u>CLIN. REC., VET. ADM. HOSPITAL, FT. HOWARD, MD</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				APPROX. <u>4</u> MOS.			
<u>422.1</u>							
IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>							
ANTECEDENT CAUSE (B) <u>DUE TO</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) <u>DUE TO</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>BRONCHOPNEUMONIA, BILATERAL, BASILAR</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>MARCH 2, 1955</u> , to <u>MARCH 4, 1955</u> , and that death occurred at <u>9:00AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Francis G. Dickey</u>		ADDRESS <u>VAH, FT. HOWARD, MD</u>		DATE SIGNED <u>3/4/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>3-8-55</u>		<u>MOUNT CATHARY CEMETERY</u>		<u>BALTIMORE, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3-7-55</u>		<u>A. W. Hemsley</u>		<u>Mrs. Samuel T. Hemsley</u>		<u>578 W. Middle St., Balto., Maryland</u>	





2392

## CERTIFICATE OF DEATH

Reg. Dist. No.

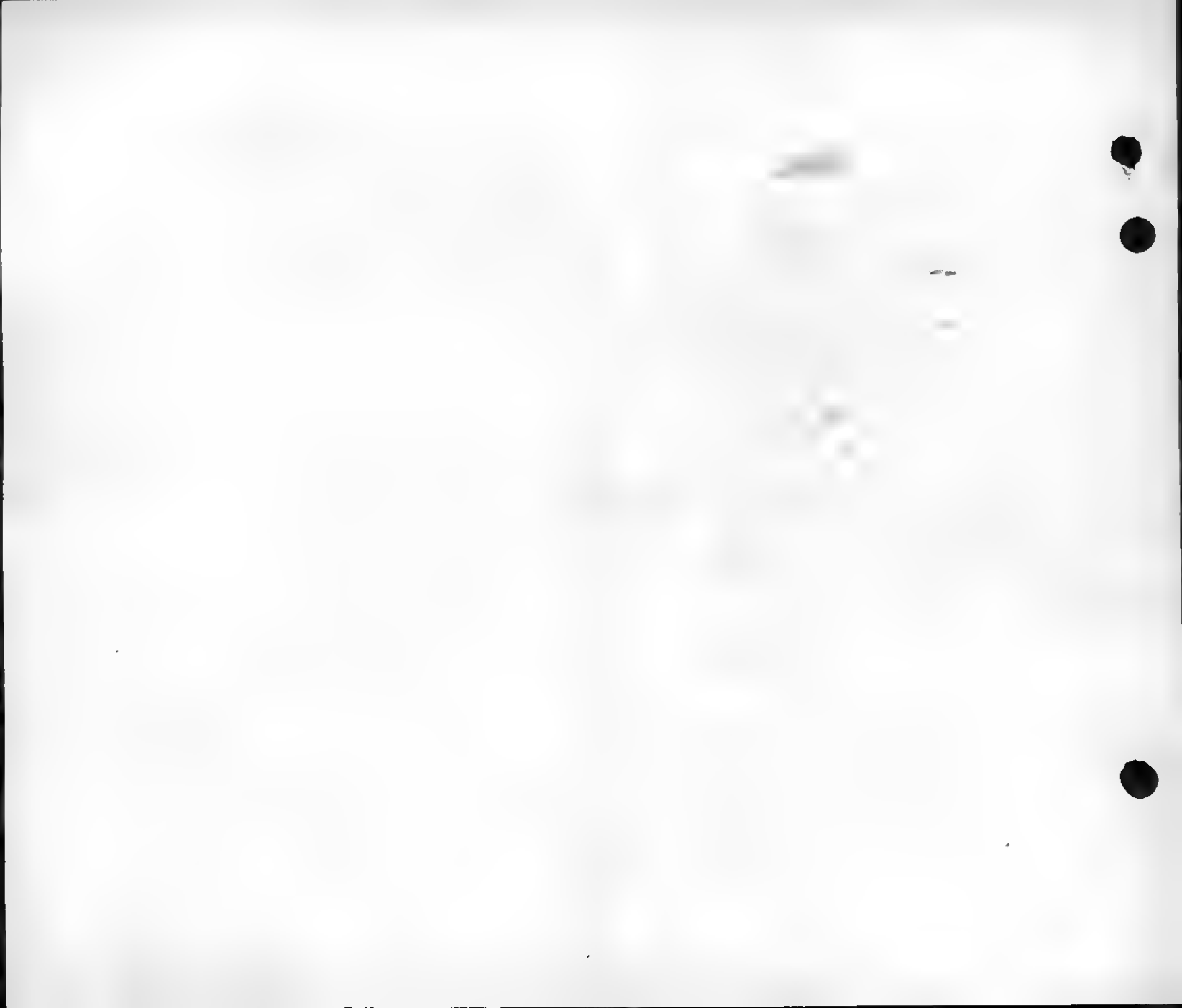
1. PLACE OF DEATH: Eudowood San. Towson 4 COUNTY Baltimore MARYLAND CITY (If outside corporate limits, write RURAL LENGTH OF STREET OR and give nearest town) (in this place) X TOWN Rural: Towson HOSPITAL OR INSTITUTION OR STREET ADDRESS Eudowood Sanatorium Towson 4, Maryland		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY BALTO. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE 3V01... STREET ADDRESS (If rural give location) 4512 Old Frederick Rd.	
3. NAME OF DECEASED: (Type or Print) William (First) L (Middle) Iardella (Last)		4. DATE OF DEATH: MARCH 4 1955	
5. SEX: MALE	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED	8. DATE OF BIRTH: 4-30-87
9. AGE at birthday: 67 yrs.		10. MONTHS Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: CIVIL ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: WALTER L. IARDELLA		14. MOTHER'S MAIDEN NAME: ANNA LYNCH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY No.: NONE	
17. INFORMANT & ADDRESS: Personal History Hospital Records, Eudowood Sanatorium			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) Pulmonary Tuberculosis Antecedent causes (s) (b) Peptic Ulcer Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) Arteriosclerosis, general		84+2 24+2 Leuk.
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION: 1955		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2/17, 1955, to 3/4, 1955, that I last saw the deceased alive on 3/4, 1955, and that death occurred at 7:00 PM, from the causes and on the date stated above.					
SIGNATURE: Milton B. Kress		ADDRESS: Eudowood Sanatorium, Towson 4, Maryland		DATE SIGNED: 3/8/55	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF: 3/8/55	NAME OF CEMETERY OR CREMATORY: Linden Lake Burial		LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REGISTRAR: 3-7-55		REGISTRAR'S SIGNATURE: C. W. Redman		24. GENERAL DIRECTOR: Donald Luck	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02371

Item 9, Film 180 4-11-55 at

2393

## CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>B</u>
CITY <u>Cockeysville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>York Road</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>IRWIN MELVILLE ISAACS</u>		<u>7/20/19</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>May 6, 1904</u>
9. AGE last birthday <u>77</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Bradley Isaacs</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Blanche Isaacs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Family Records</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
4. IMMEDIATE CAUSE		<u>Less than 24 hours</u>	
(A) <u>Acute myocardial infarction</u>			
ANTECEDENT CAUSE (B)		<u>and several years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B) <u>coronary thrombosis</u>			
DUE TO			
(C) <u>atherosclerosis</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
2 I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>Mar 30</u> , 19 <u>55</u> that I last saw the deceased alive on <u>Mar 28</u> , 19 <u>55</u> , and that death occurred at <u>6:50 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>James R. Fowler</u>		ADDRESS <u>M.D. Lombard &amp; Co. Baltimore, Md</u>	
DATE SIGNED <u>Mar 30, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Buried</u>		<u>April 3, 1955</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Landon Park Cemetery</u>		<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>April 1955</u>		<u>Gene Amistead MacRae</u>	
FUNDAL DIRECTOR		ADDRESS	
<u>John Burns' Sons</u>		<u>Baltimore, Md</u>	

7.1. 1971

1. 1. 1971

1. 1. 1971

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

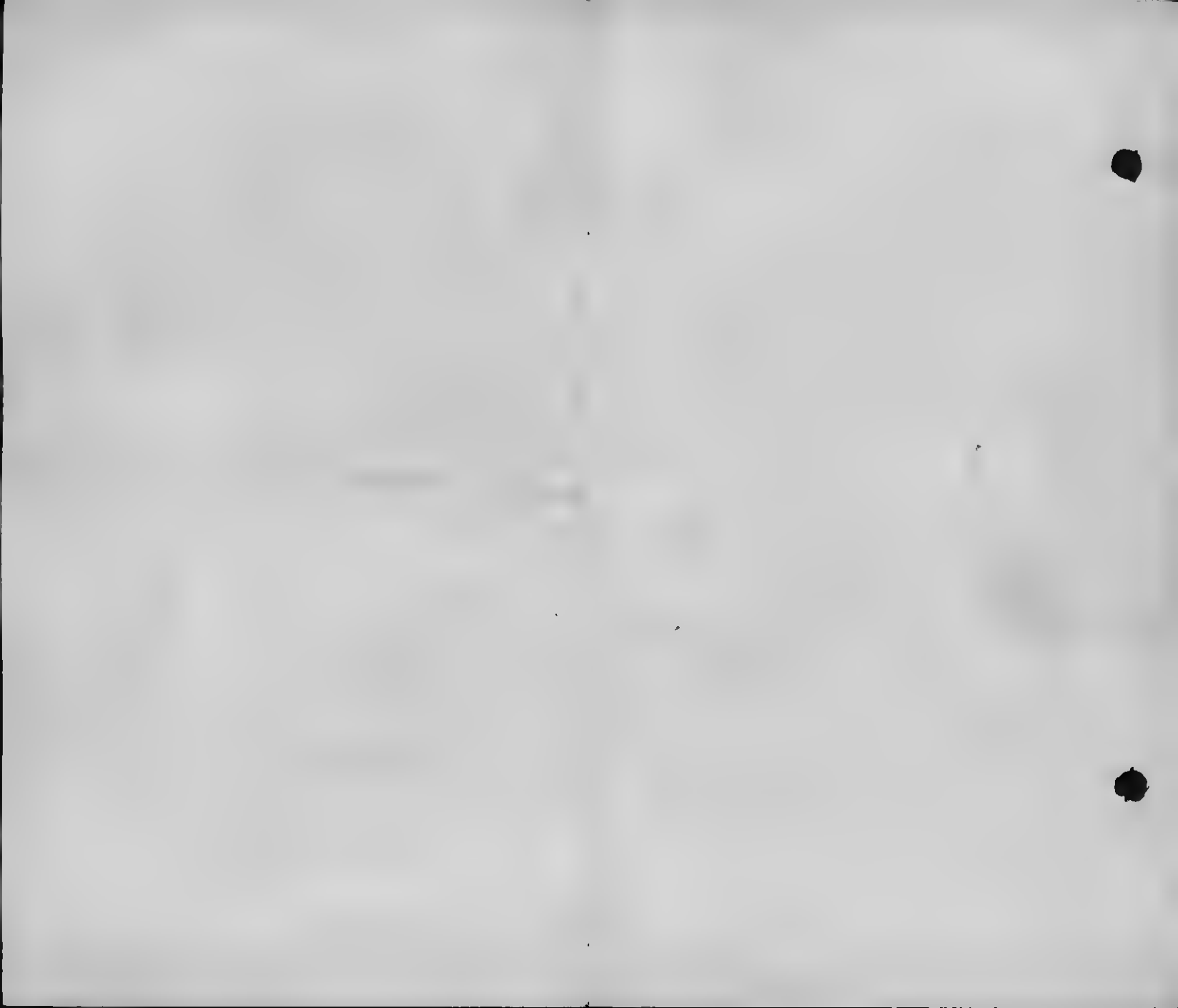
2394 11-219 3-71-0. st

02372  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. ....

<b>1. PLACE OF DEATH:</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<input checked="" type="checkbox"/> TOWN <u>Brown Oak Jct. Balto.</u>		<u>2 yrs</u>		<input checked="" type="checkbox"/> TOWN <u>Brown Oak Jct. Balto.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
<u>Milford Mill Rd.</u>				<u>Milford Mill Rd.</u>			
<b>3. NAME OF DECEASED:</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>THOS. LANDAN JACKSON</u>				<u>Mar 23 1955</u>			
<b>5. SEX:</b>		<b>6. COLOR OR RACE:</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):</b>		<b>8. DATE OF BIRTH:</b>	
<u>Male</u>		<u>colored</u>		<u>married</u>		<u>Sept 30 '70</u>	
<b>9. AGE last birthday:</b>		<b>10. BIRTHPLACE</b> (State or foreign country):		<b>11. CITIZEN OF WHAT COUNTRY?</b>		<b>12. IF UNDER 1 YEAR</b> (Months) (Days) (Hours) (Min.)	
<u>77 yrs.</u>		<u>Fagvier Co. Va.</u>		<u>W.S.A.</u>			
<b>13. FATHER'S NAME:</b>				<b>14. MOTHER'S MAIDEN NAME:</b>			
<u>Thos. Landan Jackson</u>				<u>Martin Ellen (nee)</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY No.:</b>		<b>17. INFORMANT &amp; ADDRESS:</b>			
<u>No.</u>		<u>None</u>		<u>Ellen Jane Jackson (wife)</u>			
<b>18. MEDICAL CERTIFICATION</b>							
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>331X</u> Immediate cause (a) <u>Cerebral Hemorrhage</u> DUE TO						<u>7 hrs.</u>	
Antecedent cause(s) (b) <u>None</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>None</u>							
<b>19a. DATE OF OPERATION:</b>				<b>19b. MAJOR FINDING OF OPERATION:</b>			
<u>None</u>				<u>None</u>			
<b>21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.</b>		<b>21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY</b>		<b>21c. (City or town) (County) (State)</b>		<b>20. AUTOPSY?</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<u>None</u>		<u>None</u>		<u>None</u>			
<b>21d. TIME (Month) (Day) (Year) (Hour) OF INJURY</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<u>None</u>		<u>M.</u>		<u>None</u>			
<b>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>SIGNATURE</b>		<b>CHIEF MEDICAL EXAMINER</b>		<b>DEPUTY MEDICAL EXAMINER</b>		<b>DATE SIGNED</b>	
<u>D. D. Caples</u>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<u>3-23-55</u>	
<b>23. BURIAL, CREMATION, REMOVAL. (Specify):</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>3/26/55</u>		<u>St. Thomas Cem. Balto Co, Md</u>			
<b>DATE REC'D BY LOCAL REG.</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>24. FUNERAL DIRECTOR</b>		<b>ADDRESS</b>	
<u>March 26 1955</u>		<u>R.W.</u>		<u>Rayner Sanders</u>		<u>217 E. Preston St.</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2315

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

02373

Reg. Dist. No. 41

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 22</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>502 New Pittsburgh Ave.</u>				STREET ADDRESS (If rural, give location) <u>502 New Pittsburgh Ave.</u>			
3. NAME OF DECEASED (Type or Print)		(First) <u>Jannie</u>		(Middle) <u>Young</u>		(Last) <u>James</u>	
4. DATE OF DEATH		(Month) <u>March</u>		(Day) <u>18</u>		(Year) <u>1955</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>February 28, 1909</u>	
9. AGE last birthday <u>46 yrs.</u>		If under 1 year <u>1</u> Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electric Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>			
13. FATHER'S NAME <u>William Young</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Kelly</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY No. <u>217 22 7413</u>		17. INFORMANT AND ADDRESS <u>Roosevelt James 502 New Pittsburgh Ave #22</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
171X Immediate cause (a) <u>Broncho-pneumonia</u>						<u>2 days</u>	
Antecedent cause(s) (b) <u>Carcinoma of Cervix</u>						<u>?</u>	
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>February 12, 1955</u> , to <u>March 18, 1955</u> , that I last saw the deceased alive on <u>March 18, 1955</u> , and that death occurred at <u>8:30</u> m., from the causes and on the date stated above.							
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED	
<u>William C. Hoke M.D.</u>		<u>140 Oak Avenue, Dundalk 22, Md</u>		<u>March 18, 1955</u>			
23. BURIAL CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3-22-55</u>		<u>Arbutus Memorial Park</u>		<u>Arbutus, Maryland</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3-22-55</u>		<u>W. C. Hoke</u>		<u>Charles R. Law</u>		<u>802 Madison Ave.</u>	





2395

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Ann Arundel</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 TOWN Catonsville</u>	LENGTH OF STAY (in this place) <u>5 mo. 14 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>TOWN Annapolis</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>3 Mile Oak</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Angeline Jenkins</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>March 9, 19 55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>2-1-1871</u>
9. AGE last birthday: <u>84</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housework</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>HOME</u>	
11. BIRTHPLACE (State or foreign country): <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Daniel Moore</u>		14. MOTHER'S MAIDEN NAME: <u>Martha Moore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO: <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hosp.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<u>422.1</u>			
IMMEDIATE CAUSE (A) <u>Cardiac failure</u>			
ANTECEDENT CAUSE (S) DUE TO <u>Arteriosclerotic c. v. disease</u>			Years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
22. I hereby certify that I attended the deceased from <u>9-23-</u> , <u>1954</u> to <u>3-9-</u> , <u>1955</u> , that I last saw the deceased alive on <u>3-9-</u> , <u>1955</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>S. Wachler</u>		ADDRESS <u>Spring Grove State Hospital</u> DATE SIGNED <u>3-9-55</u>	
M.D. <u>Catonsville</u>		LOCATION (City, town, or county) (State) <u>MD.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3/11/55</u>	
NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN</u>		LOCATION (City, town, or county) (State) <u>GLEN BURNIE MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>March 11, 1955</u>		REGISTRAR'S SIGNATURE <u>Victor E. Harvey</u>	
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR + SONS</u>		ADDRESS <u>Annapolis</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 15 1955

BUREAU A. S.

2396

02375

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

No. 30

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Baltimore</u>		MARYLAND	STATE <u>Maryland</u>		COUNTY <u>Prince George</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place) <u>1yr. 1mo. 4day</u>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Colmar Manor</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>			STREET ADDRESS (If rural, give location) <u>3605 40th Place</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>John E. Joeckel</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 17, 19 55</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>2-8-1878</u>	9. AGE last birthday: <u>77</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>George Joeckel</u>			14. MOTHER'S MAIDEN NAME: <u>Barbara Anna</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY No.: <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
<u>423.1</u> Immediate cause (a) <u>Coronary thrombosis</u> DUE TO Antecedent cause(s) (b) <u>Generalized arteriosclerosis</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u>Arteriosclerotic heart disease</u>		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus--Cirrhosis of liver</u>	
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY
21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
21f. HOW DID INJURY OCCUR?	

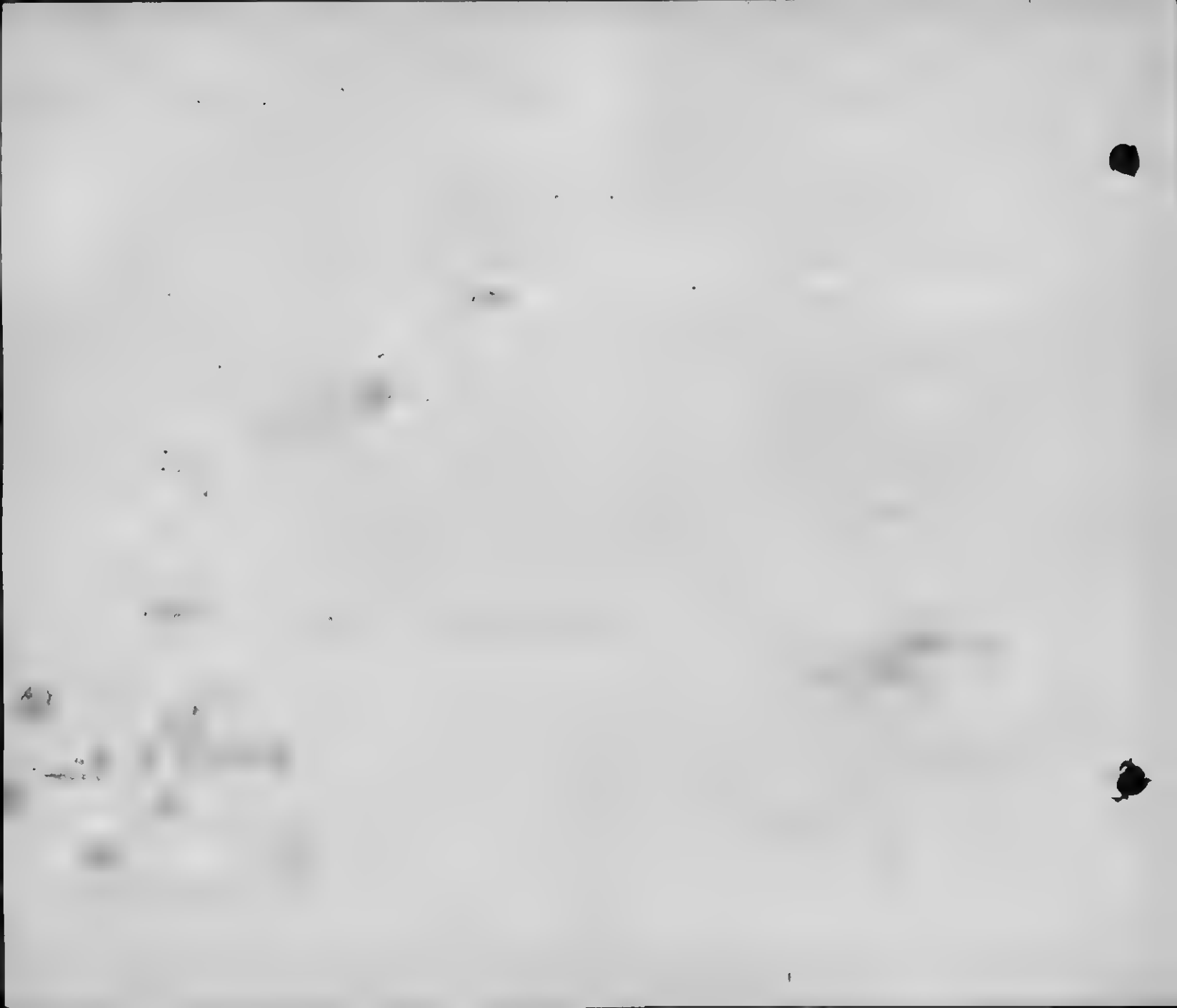
22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Leo M. Kieffer 1010 Seelan  
 CHIEF MEDICAL EXAMINER ☒ DATE SIGNED 3-17-55  
 DEPUTY MEDICAL EXAMINER ☐  
 M. D. ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>3/19/55</u>	NAME OF CEMETERY OR CREMATORY: <u>St. Lincoln</u>	LOCATION (City, town, or county) (State): <u>Colmar Manor, Md</u>
DATE REC'D BY LOCAL REG. <u>3/18/55</u>	REGISTRAR'S SIGNATURE: <u>Amanda Murray</u>	24. FUNERAL DIRECTOR: <u>F. J. Sone, Hyattsville, Md</u>	
3-21-55		V.E. Harry	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 102376 42

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Hartford</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Relay, 27</u>	LENGTH OF STAY (in this place) <u>1 year 24 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Holland's Hill</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Relay Hill Hosp. Relay 27, Md</u>		STREET ADDRESS (If rural give location) <u>Levyman</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		DATE OF DEATH: (Month) (Day) (Year)	
<u>Oscar M Johnson</u>		<u>March 5 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>Jan 31-1873</u>
9. AGE last birthday: <u>82</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Farm</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME: <u>George Johnson</u>		14. MOTHER'S MAIDEN NAME: <u>Katie V. Halloway</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.: <u>—</u>	
17. INFORMANT & ADDRESS: <u>Relay Hill Hosp. Relay Maryland</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			Interval Between Onset And Death
493X Immediate cause (a) <u>Pulmonary Edema</u>			<u>6 hours</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Pneumonia, Rt. Lung</u>			<u>10 days</u>
(c)			
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertrophic Arthritis, Generalized</u>			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>Jan 31, 1954</u> , to <u>March 5, 1955</u> , that I last saw the deceased alive on <u>March 5, 1955</u> , and that death occurred at <u>10:50 PM</u> from the causes and on the date stated above.			
SIGNATURE <u>Lewis P. Funk M.D.</u>		ADDRESS <u>Relay Hill Hosp. March 5, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Burial</u>		<u>March 8-1955</u>	<u>Spesutie Cemetery</u>
LOCATION (City, town, or county) (State)			
<u>Levyman Maryland</u>			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
<u>March 19-55</u>		<u>George S.M. Keffert</u>	<u>John F. Barring Aberdeen Md</u>
		ADDRESS	

BUREAU V. S.

MAR 15 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02377  
2397 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH: <b>TOWSON</b>				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Balto.</b> City	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>55 TOWN</b>		LENGTH OF STAY (in this place) <b>12 days</b>		CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>TOWN Baltimore</b>		<b>3Y01-4</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>19 Sheppard &amp; Enoch Pratt Hosp. Towson 4, Maryland</b>				STREET ADDRESS (If rural give location) <b>4818 Greenspring Avenue</b>			
3. NAME OF DECEASED: (First) <b>Elsie</b>		(Middle) <b>Strouse</b>		(Last) <b>Kaufman</b>		4. DATE OF DEATH: (Month) <b>March</b> (Day) <b>19</b> (Year) <b>1955</b>	
5. SEX: <b>Female</b>		6. COLOR OR RACE: <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Widow</b>		8. DATE OF BIRTH: <b>Oct. 8, 1882</b>	
				9. AGE last birthday: <b>72</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION: Give kind of work done during most of working life, even if retired: <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <b>Baltimore, Maryland</b>	
13. FATHER'S NAME: <b>Samuel Strouse</b>				14. MOTHER'S MAIDEN NAME: <b>Bertha Samstag</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <b>No</b>		16. SOCIAL SECURITY No.: <b>---</b>		17. INFORMANT & ADDRESS: <b>Hospital records</b>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<b>322X Immediate cause</b>		<b>4 weeks</b>
(a) <b>Cerebral thrombosis</b>		
DUE TO		
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		<b>Unk.</b>
(b) <b>Generalized arteriosclerosis</b>		
DUE TO		
(c)		

11. OTHER SIGNIFICANT CONDITIONS		Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction.	
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY ?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
SUICIDE		(CITY OR TOWN) (COUNTY) (STATE)	
HOMICIDE		INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR ?			

22. I hereby certify that I attended the deceased from **March 6, 1955**, to **March 19, 1955**, that I last saw the deceased alive on **March 18, 1955**, and that death occurred at **2:30 a.m.**, from the causes and on the date stated above.

SIGNATURE **M. D. Assistant Medical Supt., Sheppard-Pratt Hospital** DATE SIGNED **3/19/55**

23. BURIAL CREMATION, REMOVAL (Specify) **3-21-55 Wash. Hebrew Congregation Cem Wash. D.C.**

DATE REC'D BY LOCAL REGISTRAR **Mar. 19, 1955** REGISTRAR'S SIGNATURE **Mabel C. Gray**

24. FUNERAL DIRECTOR **David R. Norton, 1902 Newton Place** ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

EDWARD V.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02379  
2398 CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rosedale</u>		<u>11 ft</u>		X TOWN <u>Rosedale</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1028 Sumter Ave.</u>				STREET ADDRESS (If rural give location) <u>1028 Sumter Ave</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>John George Kipp Sr.</u>				<u>March 4 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>July 30th 1881</u>	
				9. AGE last birthday: <u>73</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Floor Covering</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Own business</u>		11. BIRTHPLACE (State or foreign country): <u>Balto. Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>Elias Kipp</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Darnay</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>212-34-8805</u>		17. INFORMANT & ADDRESS: <u>Mrs. John G. Kipp 1028 Sumter Ave</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<p>422.1 Immediate cause (a) <u>Coronary Occlusion</u></p> <p>Antecedent causes (s) (b) <u>Arteriosclerotic Cardio-Vascular disease</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)</p>							
Interval Between Onset And Death <u>Sudden</u>							
Interval Between Onset And Death <u>2 years</u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)				PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work Not While At Work		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 1 1954</u> to <u>March 4 1955</u> , that I last saw the deceased alive on <u>March 4 1955</u> , and that death occurred at <u>9 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>J. Baumgardner MD</u>				DATE SIGNED <u>3/4/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/8/55</u>		<u>Oak Lawn</u>		<u>Balto. Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3/8/55</u>		REGISTRAR'S SIGNATURE <u>Edith Hurley</u>		24. FUNERAL DIRECTOR <u>Lansden Funeral Home</u>		ADDRESS <u>4401 Bz 1 air</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.

APR 11 1965

10-11-65

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02380

2399

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

Item 2, Film 178 3-15-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Id.</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Baltimore</u>		<u>1</u>		TOWN <u>Rural - Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>4605 York Rd.</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) <u>Cecelia</u>		(Middle)		(Last) <u>Klug</u>		(Day) <u>3</u> (Month) <u>10</u> (Year) <u>1955</u>	
(Type or Print)							
5. SEX. <u>Female</u>	6. COLOR OR RACE. <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>Single</u>	8. DATE OF BIRTH: <u>Dec. 1, 1911</u>	9. AGE last birthday <u>43</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Accountant</u>		<u>Accountant</u>		<u>Baltimore, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME: <u>William J. Klug</u>				14. MOTHER'S MAIDEN NAME: <u>Appolonis A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				17. INFORMANT & ADDRESS:			
				<u>Dr. Robert A. Galt, 5222 E. Baltimore Ave.</u>			
16. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						<u>Sudden</u>	
ANTECEDENT CAUSE (B) <u>Hypertensive Cardiac Renal</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Vascular Disease</u>						<u>10 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 1953</u> to <u>March 6, 1955</u> , that I last saw the deceased alive on <u>March 5, 1955</u> , and that death occurred at <u>8:20 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Charles F. O'Donnell</u>		M.D. <u>7501 York Rd</u>		DATE SIGNED <u>3/7/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>March 9, 1955</u>		<u>St. John's</u>		<u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>J. H. Hedrick</u>		24. FUNERAL DIRECTOR		ADDRESS	
<u>3/8/55</u>				<u>W. A. Hedrick</u>		<u>1114 E. 1st St.</u>	



2400

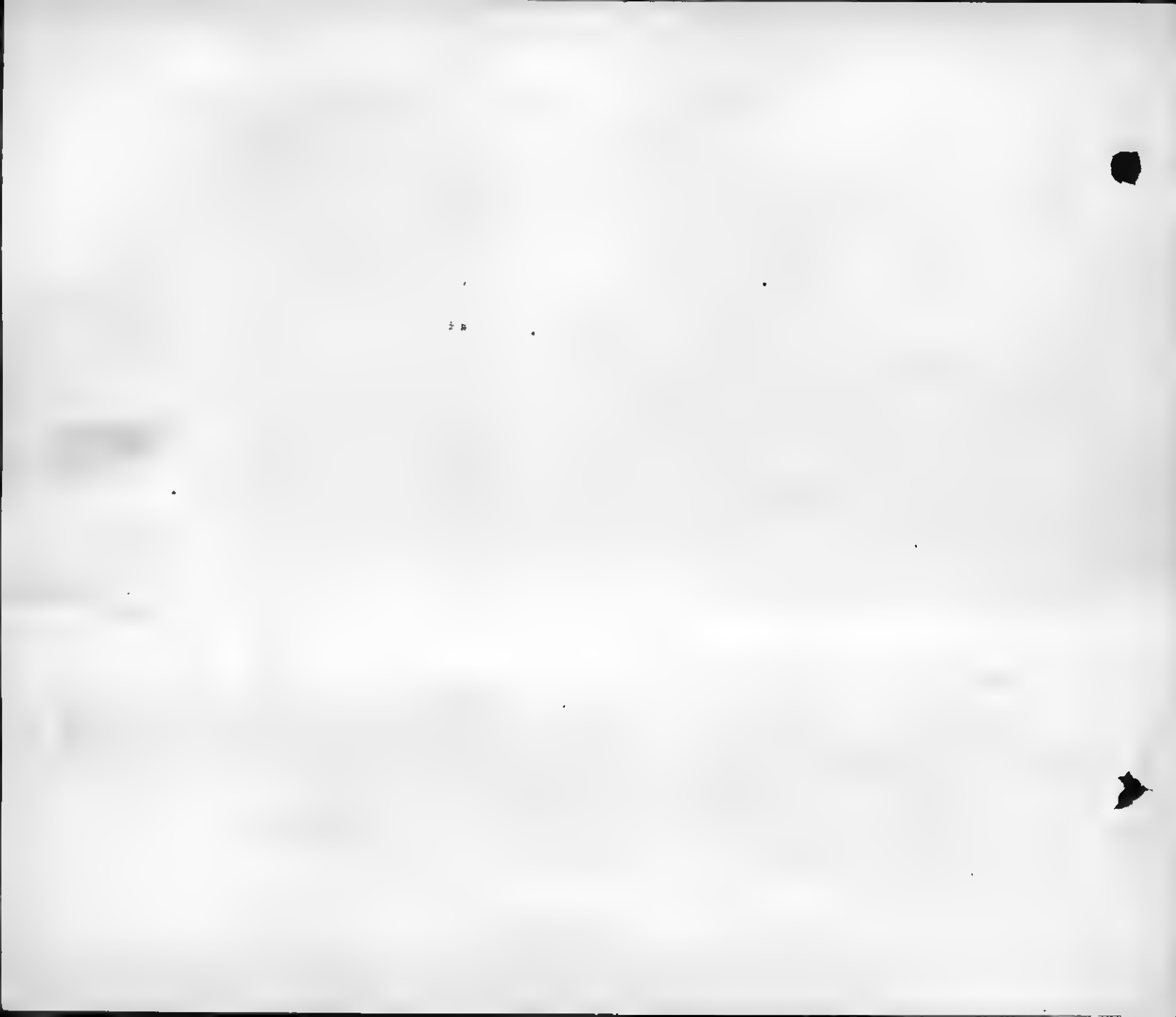
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED.			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>McDonogh</u>		<u>2 weeks</u>		OR TOWN <u>Baltimore City</u>		<u>50-1-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>2827 Rayner Avenue</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Katie A. Kohlstead</u>				<u>March 20, 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Aug. 17, 1869</u>	<u>85</u> yrs	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>At Home</u>						<u>Baltimore County Maryland</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Tobias Schaar</u>				<u>Caroline Poehlman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>No</u>						<u>Carl Heinmuller</u>	
18. MEDICAL CERTIFICATION				<u>McDonogh Road McDonogh Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
420.9 IMMEDIATE CAUSE				<u>2 weeks</u>			
ANTECEDENT CAUSE (S)				<u>2 weeks</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<u>parent disease with 8 yr</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1954</u> to <u>1955</u> that I last saw the deceased alive on <u>11/19/55</u> and that death occurred at <u>2 P. M.</u> from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>March 23, 1955</u>		<u>Loudon Park Cemetery</u>		<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3-22-55</u>		<u>G. W. H. H. H.</u>		<u>Ellsworth Armacost</u>		<u>4600 Liberty Heights Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

<b>1. PLACE OF DEATH</b> COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u> OR TOWN <u>Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wayne Conv. Home 98 Smithwood</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> STATE <u>MD.</u> COUNTY <u>BALTIMORE</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> OR TOWN <u>Baltimore</u> STREET ADDRESS (If rural give location) <u>612 S. Ann St.</u>					
<b>3. NAME OF DECEASED:</b> (First) (Middle) (Last) <u>JAMES</u> <u>KOMODER</u>				<b>4. DATE OF DEATH:</b> (Month) (Day) (Year) <u>March 12</u> <u>19</u> <u>55</u>					
<b>5. SEX:</b> <u>male</u>		<b>6. COLOR OR RACE:</b> <u>W</u>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED.</b> (Specify): <u>W</u>		<b>8. DATE OF BIRTH:</b> <u>July 22 1894</u>		<b>9. AGE last birthday:</b> <u>60</u> yrs IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.:	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired): <u>Laborer</u>				<b>10B. KIND OF BUSINESS OR INDUSTRY:</b> <u>waterfront</u>		<b>11. BIRTHPLACE</b> (State or foreign country): <u>Poland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME:</b> <u>ANDREW KOMODER</u>						<b>14. MOTHER'S MAIDEN NAME:</b> <u>BRILL</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war, or dates of service) <u>Yes</u>				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS:</b> <u>Stella M. K 3630 Chestersfield, Balto. Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>								<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b> <b>334X</b> IMMEDIATE CAUSE <u>CEREBRAL ATROPHY SECONDARY TO ARTERIOSCLEROSIS</u> ANTECEDENT CAUSE (S): <u>GENERALIZED ARTERIOSCLEROSIS</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (C)								(A) <u>DUE TO</u> (B) <u>DUE TO</u> (C)	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>									
<b>19A. DATE OF OPERATION:</b> <u>July 1953</u>				<b>19B. MAJOR FINDINGS OF OPERATION:</b> <u>Trophine negative for surgical brain lesion</u>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>21B. PLACE (Home, farm, factory, etc.) OF INJURY</b> street, office bldg., etc.		<b>21C. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21D. TIME (Month) (Day) (Year) (Hour) OF INJURY</b> M.				<b>21E. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Oct. 1953</u> <b>and that death occurred at</b> <u>March 12 1955</u> <b>, that I last saw the deceased</b> <u>active on March 10, 1955</u> <b>and that death occurred at</b> <u>3-30P</u> <b>M, from the causes and on the date stated above.</b> SIGNATURE <u>[Signature]</u> ADDRESS <u>M. 6707 Edmondson av. 3-11-55</u> DATE SIGNED									
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>				<b>DATE THEREOF</b> <u>3-15-55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>USN CEM.</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Balto. Md.</u>	
<b>DATE REC'D BY LOCAL REGISTRAR</b> <u>3-15-55</u>				<b>REGISTRAR'S SIGNATURE</b> <u>V.E. HARRY</u>		<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>MacNABB &amp; SON CATONSVILLE MD. 28</u>			





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

247117e 7, Film 178 3-15-55 et  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02382  
 Reg. Dist.

No. ....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>BALTIMORE</b>	MARYLAND	STATE <b>Md.</b>	COUNTY <b>Balto.</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Cockeysville</b>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <b>Parkton</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
(First) <b>JOSEPH</b> (Middle) <b>PETER</b> (Last) <b>KOZLOWSKI</b>		(Month) <b>3</b> (Day) <b>5</b> (Year) <b>1955</b>	
5. SEX: <b>M</b>	6. COLOR OR RACE: <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Single</b>	8. DATE OF BIRTH: <b>Apr. 15, 1931</b>
9. AGE last birthday: <b>23</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>window cleaner</b>		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Charles Kozlowski</b>		14. MOTHER'S MAIDEN NAME: <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: <b>Cockeysville Police</b>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
<b>871.6</b> Immediate cause (a) <b>Barbiturate poisoning</b> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <b>home</b> )	21c. (City or town) <b>Parkton</b> (County) <b>Baltimore</b> (State) <b>Md.</b>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>March 5, 1955</b> <b>M.</b>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>Ingested barbiturate</b>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <b>Paul F. Grier</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>3-5-55</b> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM.	
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Removal</b>	DATE THEREOF <b>3-5-55</b>	NAME OF CEMETERY OR CREMATORY	
LOCATION (City, town, or county) <b>Wilmington, De.</b> (State)			
DATE REC'D BY LOCAL REG. <b>March 7, 1955</b>		24. FUNERAL DIRECTOR <b>R. L. Kaczorowski-2525 Fleet St.</b> ADDRESS	



2492

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Cockeysville</u>		<u>4 yrs.</u>		OR TOWN <u>Cockeysville</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Paper Mill Rd.</u>				STREET ADDRESS (If rural give location) <u>Paper Mill Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Charles Robert KRUGER SR.</u>				OF DEATH: <u>MAR. 4</u> (4) 19 <u>55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>W</u>	<u>Married</u>	<u>8 Dec 1896</u>	<u>58</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
				<u>Florist</u>		<u>Woodlawn, Md.</u>	
13. FATHER'S NAME:				12. CITIZEN OF WHAT COUNTRY?			
<u>August KRUGER</u>				<u>USA.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
						<u>Daughter. (same)</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Epileptiform Seizures</u>							
ANTECEDENT CAUSE (B) <u>Intracranial Neoplasm. (type undiagnosed)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug</u> , 19 <u>54</u> , to <u>4 MAR</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>15 Feb</u> , 19 <u>55</u> , and that death occurred at <u>9:40 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Thomas A. E. Mowley</u> M.D.				ADDRESS <u>Cockeysville, Md.</u>		DATE SIGNED <u>4 Mar '55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>MAR. 8, 1955</u>		<u>CATHEDRAL</u>		<u>BALTO MD</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>14 March 1955</u>		<u>Ann Armitstead MacRae</u>		<u>MACNABB &amp; SON</u>			

MARGIN RESERVED FOR BINDING

# 1153  
p. 50 d

BUREAU V. S.

MAR 16 1955

RECEIVED

243

02385

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town)	OR TOWN <u>Parkville, Balto 14.</u>
TOWN <u>same</u>	<u>6 mo</u>	STREET ADDRESS (If rural give location)	<u>4819 Bagley Ave.</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF DECEASED:		4. DATE OF DEATH	
(Type or Print) <u>Thomas J. Parkin</u>		(Month) (Day) (Year) <u>Mar 30 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH: <u>Nov 18/1874</u>
9. AGE last birthday: <u>80 yrs</u>		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired</u>		11b. KIND OF BUSINESS OR INDUSTRY: <u>Retired</u>	
12. BIRTHPLACE (State or foreign country): <u>Baltimore City</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. FATHER'S NAME: <u>Thomas J. Parkin</u>		15. MOTHER'S MAIDEN NAME: <u>Mary Ashton</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. SOCIAL SECURITY No.: <u>Mr. Margaret Parkin (Wife)</u>	
18. INFORMANT & ADDRESS:			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
430.1 Immediate cause		(a)..... <u>Coronary occlusion</u>	<u>Immediate</u>
Antecedent cause(s)		DUE TO	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(b)..... DUE TO	
(c)			

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) <u>Mar 3 30 55 5 PM</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Dr. J. M. Parkin M. D. DR CHIEF MEDICAL EXAMINER ☒ DEPUTY MEDICAL EXAMINER ☐ DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>4-2-55</u>	NAME OF CEMETERY OR CREMATORY: <u>Parkwood Cem.</u>	LOCATION (City, town, or county) (State): <u>Balto MD</u>
DATE REC'D BY LOCAL REG. <u>3/31/55</u>	REGISTRAR'S SIGNATURE: <u>Dr. J. M. Parkin</u>	24. FUNERAL DIRECTOR: <u>Ronald J. Ruck</u>	ADDRESS: <u>5305 Harford</u>

MARGIN RESERVED FOR BINDING

VS. A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02386

## 2424 CERTIFICATE OF DEATH

Reg. Dist. No.

Item 9, Film 6179 4-5-55 et

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Pa.</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Catonsville</u>		TOWN <u>East Berlin</u> <u>75 x 2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ridgeway Manor</u> <u>5743 Edmondson Ave.</u>	STREET ADDRESS (If rural give location) <u>--</u> <u>✓</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
AMANDA L. LAU		DATE OF DEATH: <u>March</u> <u>28</u> <u>1955</u>	
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: Mar. 5, 1869
9. AGE last birthday: 86 <u>1/4</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife (rtd)</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>	
11. BIRTHPLACE (State or foreign country): <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Joseph Leib</u>		14. MOTHER'S MAIDEN NAME: <u>Susan Sewers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Mr. Joseph L. Lau-628 Longview Drive 28</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>PULMONARY EDEMA</u>			
ANTECEDENT CAUSE (B) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>SENILE ARTERIOSCLEROSIS</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>April, 1954</u> to <u>MARCH 1955</u> , that I last saw the deceased alive on <u>Mar 28, 1955</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>R. V. Souk</u>		DATE SIGNED <u>Mar 3-29-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>3/31/55</u>	
NAME OF CEMETERY OR CREMATORY <u>East Berlin Union Cem.</u>		LOCATION (City, town, or county) (State) <u>East Berlin, Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-20-55</u>		REGISTRAR'S SIGNATURE <u>E. W. Hedrick</u>	
24. FUNERAL DIRECTOR <u>Wm. J. Pickner &amp; Sons - Baltimore</u>		ADDRESS	





2405

## MARYLAND STATE DEPARTMENT OF HEALTH

02387

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH - COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glenarm</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glenarm</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Belair Road</u>		STREET ADDRESS (If rural, give location) <u>Belair Road</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>M. MAMIE LAUBACH</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 4th 1955</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept. 6, 1883</u>
9. AGE last birthday <u>71</u> yrs.		10. If under 1 year: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Mins. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Seibert</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. James Girvin, Pelair Rd., Glenarm P.O.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260X Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Congestive Heart Failure  
 (b) Diabetes Mellitus  
 (c) Hypertensive Cardiovascular Disease

INTERVAL BETWEEN ONSET AND DEATH

48 hrs.

6 yrs.

2 yrs.

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, or office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at <input type="checkbox"/> Not While at <input type="checkbox"/>	HOW DID INJURY OCCUR?		
m.	Work <input type="checkbox"/> At work <input type="checkbox"/>			

22. I hereby certify that I attended the deceased from 4/21, 1949, to 3/4, 1955, that I last saw the deceased

alive on 3/4, 1955, and that death occurred at 9:25 P.M., from the causes and on the date stated above.

SIGNATURE Clifford F. Hudson, M.D. ADDRESS Fork, Md. DATE SIGNED 3/5/55

23. BURIAL OR CREMATION REMOVAL (Specify) <u>burial</u>	DATE THEREOF <u>Mar. 7, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	LOCATION (City, town, or county) <u>Balto., Md.</u>	(State)
--	-------------------------------------	---	--	---------

DATE REC'D BY LOCAL REG <u>3/5/55</u>	REGISTRAR'S SIGNATURE <u>William H. ...</u>	24. FUNERAL DIRECTOR <u>Funeral Home</u>	ADDRESS <u>701 Belair Rd.</u>
--	--	---	----------------------------------

MARGIN RESERVE FOR LINING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

*[Faint, illegible handwritten notes]*

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02388

2496

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Baltimore</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <i>Cockeysville (Rural)</i>	<i>3 yrs.</i>	OR TOWN <i>Cockeysville (Rural)</i>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Western Run Rd.</i>		STREET ADDRESS (If rural give location)	<i>Western Run Rd.</i>
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<i>Joshua Henry Leaf</i>		OF DEATH: <i>3 - 25 1955</i>	
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>	8. DATE OF BIRTH: <i>6-26-1868</i>
9. AGE last birthday: <i>86</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Mln.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmowner</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>farm</i>	
11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Henry Leaf</i>		14. MOTHER'S MAIDEN NAME: <i>Johanna Myers</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. _____	
17. MEDICAL CERTIFICATION		18. INFORMANT & ADDRESS: <i>Mrs. Margaret E. Leaf, Cockeysville, Md.</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
181X IMMEDIATE CAUSE		<i>1 yr</i>	
ANTECEDENT CAUSE (B)		<i>1 year</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		<i>general</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>✓</i>		19B. MAJOR FINDINGS OF OPERATION: <i>✓</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <i>✓</i>	
21E. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>✓</i>	
22. I hereby certify that I attended the deceased from <i>3-25-55</i> to <i>3-25-55</i> , that I last saw the deceased alive on <i>3-25-55</i> 19 <i>30</i> and that death occurred at <i>3:30</i> P. M. from the causes and on the date stated above.			
SIGNATURE <i>James C. Leaf</i>		DATE SIGNED: <i>3-26-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF: <i>3-28-55</i>	
NAME OF CEMETERY OR CREMATORY: <i>Grace Methodist</i>		LOCATION (City, town, or county) (State): <i>Cockeysville, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR: <i>29 March 1955</i>		24. FUNERAL DIRECTOR: <i>Brooks Funeral Service, Sparks, Md.</i>	
REGISTRAR'S SIGNATURE: <i>Anna Bernice MacRae</i>		ADDRESS: <i>1 Scott Brooke</i>	

RECEIVED

NOV 10 1964

LIBRARY

2477

## CERTIFICATE OF DEATH

02389

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>				STATE <u>Md.</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural: Towson</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eudowood Sanatorium Towson 4, Maryland</u>				STREET ADDRESS (If rural give location) <u>402 Woodlawn Rd</u>			
3. NAME OF DECEASED: (First) <u>Frederick W.</u> (Middle) <u>LEGG</u> (Last)				4. DATE OF DEATH: (Month) <u>March</u> (Day) <u>23</u> (Year) <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>		8. DATE OF BIRTH: <u>April 7, 1881</u>	
9. AGE last birthday: <u>73</u> yrs.		10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): <u>barber</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>EDGAR K LEGG</u>				14. MOTHER'S MAIDEN NAME: <u>Ellen Trill</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u>		16. SOCIAL SECURITY No.: <u>215-05-0363</u>		17. INFORMANT & ADDRESS: <u>DECEASED.</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Pulmonary Tuberculosis</u>		<u>5 yr.</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>none</u>		
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan 11, 1955, to March 23, 1955, that I last saw the deceased alive on March 23, 1955, and that death occurred at 2:23 A.M., from the causes and on the date stated above.

SIGNATURE Milton B. Kress (Degree or title) ADDRESS Eudowood Sanatorium, Towson 4, Md. DATE SIGNED

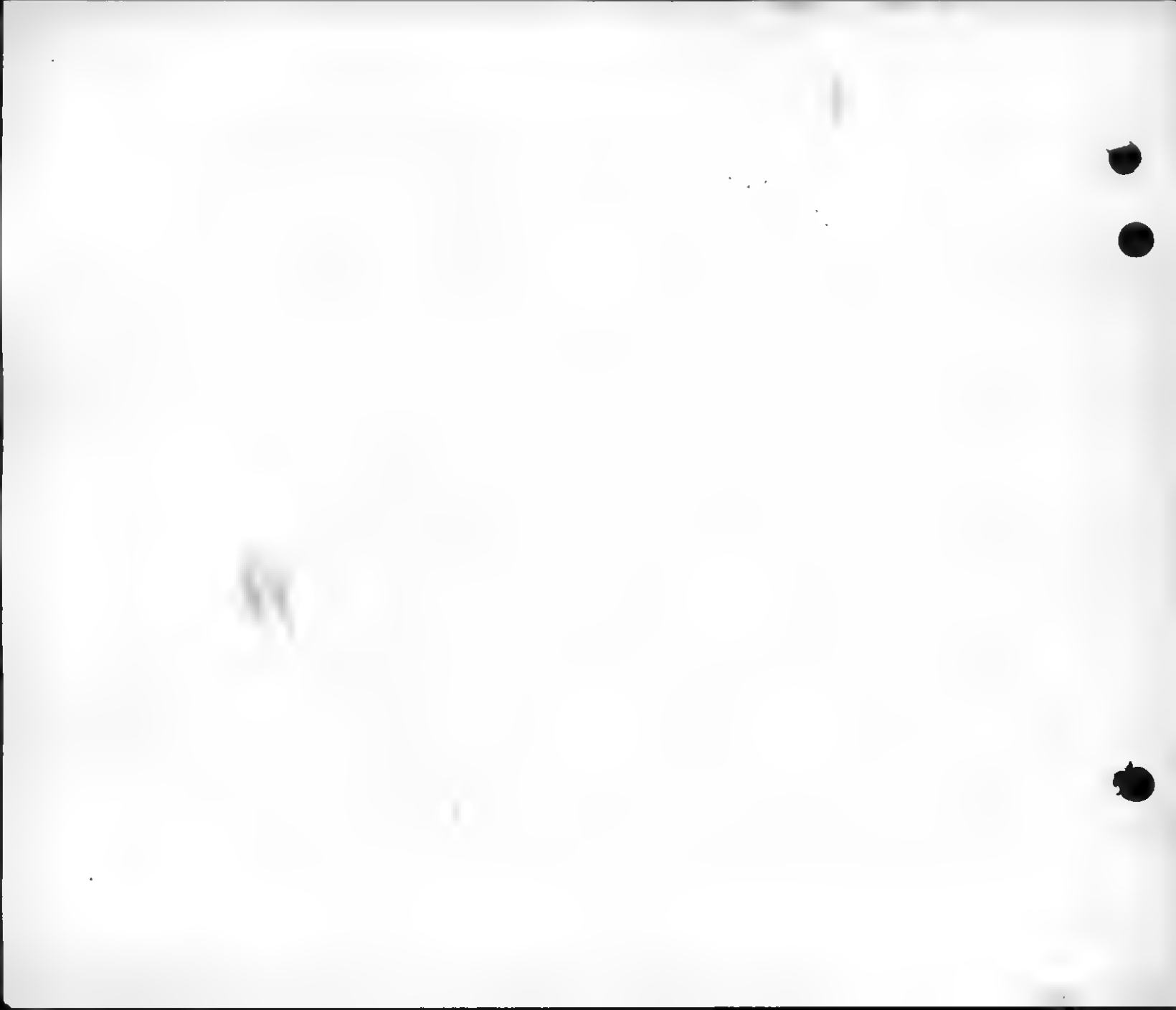
23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 3/25/55 NAME OF CEMETERY OR CREMATORY Greenwood LOCATION (City, town, or county) Baltimore (State) Md.

DATE REC'D BY LOCAL REGISTRAR 5-24-55 REGISTRAR'S SIGNATURE R. L. Hedrick 24. FUNERAL DIRECTOR Edward J. Hedrick ADDRESS 108 W. 1st St. - Baltimore

MARGIN RESERVE FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2408

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3: Film G177 3-16-55 CERTIFICATE OF DEATH

Reg. Dist. No.

02390

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MD</u> — COUNTY <u>—</u>			
CITY (If outside corporate limits write RURAL and give nearest town) <u>Catonsville</u>		LENGTH OF STAY (in this place) <u>38 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove</u>				STREET ADDRESS (If rural give location) <u>1715 Eutaw Pl.</u>		<u>3701</u>	
3. NAME OF DECEASED (Type or Print) <u>Harvey Brooke Levening</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>3</u> <u>3</u> <u>1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>3/29/1879</u>	9. AGE last birthday: <u>75</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Caret</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>—</u>		11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Wm Levening</u>				14. MOTHER'S MAIDEN NAME: <u>Cassie Broome</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT'S ADDRESS: <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pneumonia (Not typed)</u>						<u>4 days</u>	
ANTECEDENT CAUSE (B) <u>Senility</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>—</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>							
19A. DATE OF OPERATION: <u>—</u>		19B. MAJOR FINDINGS OF OPERATION: <u>—</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>—</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>—</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>1/25/55</u> , 19 <u>55</u> , to <u>3/3/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/3/55</u> , 19 <u>55</u> , and that death occurred at <u>8:30 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Charles Ward M.D.</u>		M.D. <u>Spring Grove Hosp.</u>		DATE SIGNED <u>3/3/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 10</u>		NAME OF CEMETERY OF CREMATION <u>St. Daniel Ruffe</u>		LOCATION (City, town, or county) (State) <u>Pikesville Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>—</u>		REGISTRAR'S SIGNATURE <u>—</u>		24. FUNERAL DIRECTOR <u>Stewart Mounb</u>		ADDRESS <u>Balto. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





2499

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Md</i>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Cockeysville</i>	LENGTH OF STAY (in this place) <i>1 1/2 yrs</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Baltimore</i>	<i>3861-4</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Macomic Home Cockeysville</i>		STREET ADDRESS (If rural give location) <i>4212 Penhurst Ave</i>	
3. NAME OF DECEASED: (Type or Print) <i>Emma Tolle Lewis</i>		4. DATE OF DEATH: (Month) (Day) (Year) <i>Mar. 5 1955</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE MARRIED WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <i>Aug. 14, 1870</i>
9. AGE last birthday: <i>84</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Own home</i>	
11. BIRTHPLACE (State or foreign country): <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>Henry Tolle</i>		14. MOTHER'S MAIDEN NAME: <i>Emma Overlin</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <i>A 213-34-0972</i>	
17. INFORMANT'S ADDRESS: <i>Laura M Schroeder</i>			

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
422.1		
IMMEDIATE CAUSE (A)	<i>Arterio Sclerosis</i>	<i>long</i>
ANTECEDENT CAUSE (B)	<i>Cardio Vascular Disease</i>	<i>1 1/2 yrs</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Nov 4*, 1953, to *Mar.*, 1955 that I last saw the deceased alive on *Mar 4*, 1955, and that death occurred at *7:12* A.M. from the causes and on the date stated above.

SIGNATURE <i>Valter T. Lewis</i>	DATE SIGNED <i>3/5/55</i>
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF
<i>3/8/55</i>	
NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)
<i>Woodlawn</i>	<i>Baltimore Md</i>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE
<i>3/8/55</i>	<i>Laura M Schroeder</i>
24. FUNERAL DIRECTOR	ADDRESS
<i>Wm. Cook</i>	<i>St. Paul &amp; Preston St</i>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR

MURRAY V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02392  
Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TOWN Fullerton</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) <u>TOWN Fullerton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8300 Belair Rd.</u>		STREET ADDRESS (If rural, give location) <u>8327 Belair Rd.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>AGNES</u>	(Middle) <u>H.</u>	(Last) <u>LINDLMOORE</u>	(Month) <u>March</u> (Day) <u>14</u> (Year) <u>1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>5/15-26/1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Matron</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>G. L. Martin</u>	9. AGE last birthday: <u>52</u> 50 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country): <u>Balto.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
<u>816X</u> Immediate cause (a) <u>Crushing injury of skull.</u> DUE TO Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) _____			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Street</u>	21c. (City or town) <u>Balto.</u> (County) <u>Md.</u> (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>March 14, 1955 M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>truck</u> <u>Passenger in auto which collided with</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>March 15, 55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>3/17/55</u>	NAME OF CEMETERY OR CREMATORY <u>St. Josephs</u>	LOCATION (City, town, or county) <u>Balto Co.</u> (State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>3-16-55</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>4401 Belair Ave.</u>	



2411

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02093

No. . . . .

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Baltimore</u>	MARYLAND		STATE <u>Md.</u>	COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TOWN Fullerton</u>	LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Fullerton</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8800 Belair Rd.</u>			STREET ADDRESS (If rural, give location) <u>8327 Belair Rd.</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>FORREST L. LINDIMORE</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 14, 1955</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>2/5/1902</u>		
9. AGE last birthday: <u>53</u> yrs.			10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>Sanitation</u>		
11. BIRTHPLACE (State or foreign country): <u>Ohio</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME: <u>John Lindimore</u>			14. MOTHER'S MAIDEN NAME:		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give war or dates of service) <u>World War II</u>			16. SOCIAL SECURITY No: <u>216-24-1315</u>		
17. INFORMANT & ADDRESS: <u>Geo. Schwenker</u>			<u>8327 Belair Rd</u>		

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a)..... <u>Crushing injury of chest and head</u>					
DUE TO					
Antecedent cause(s) (b).....					
Diseases or conditions, if any, giving rise to the above cause DUE TO					
stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:			19b. MAJOR FINDING OF OPERATION:		
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>street</u>		21c. (City or town) (County) (State) <u>Balto.</u> <u>Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>March 14, 1955</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Driver of auto collided with truck</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Dr. Fisher</u>		M. D. ASSISTANT MEDICAL EXAM. <u>3/15/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>3/17/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u>	
LOCATION (City, town, or county) (State) <u>Balto. Co.</u> <u>Md.</u>		24. FUNERAL DIRECTOR <u>Passan Funeral Home</u>			
DATE REC'D BY LOCAL REG. <u>3-16-55</u>		REGISTRAR'S SIGNATURE <u>W. Federal</u>		ADDRESS <u>4401 Belair</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02394

2412

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

Item 8, File 179 3-21-55 et

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTO CO.</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>BALTO.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>CATONSVILLE</u>	<u>LIFE</u>	TOWN <u>CATONSVILLE</u>	52
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>4 HOWARD AVE.</u>		<u>4 HOWARD AVE.</u>	1
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>CHARLES E.</u>	(Middle) <u>LONG</u>	OF DEATH: <u>MARCH 6 1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH: <u>FEB. 14, 1874</u>
		9. AGE last birthday: <u>80</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
<u>CLERK SPRING LAKE HOSP</u>			<u>MD.</u>
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>JOHN LONG</u>		<u>CRONHARDT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS:	
<u>NO</u>		<u>ANNA MARGARET LONG</u>	
15. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>			<u>several minutes</u>
DUE TO			
ANTECEDENT CAUSE (B) <u>Anterograde conduction disease</u>			<u>several years</u>
DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		20. AUTOPSY?	
19B. MAJOR FINDINGS OF OPERATION		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb 27, 1954</u> to <u>March 6, 1955</u> , that I last saw the deceased alive on <u>Feb 27, 1955</u> , and that death occurred at <u>9:55 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>John H. Heston, Jr.</u>		DATE SIGNED <u>M.D. 1118 St. Paul St. Balt. 2nd 3-8-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>MAR. 9, 1955</u>	<u>LORRAINE</u>	<u>WOODLAWN MD</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
<u>3-9-55</u>	<u>J.E. Harry</u>	<u>MACNABB &amp; SON</u>	

BUREAU V. S.

MAR 11



## CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Edgemere</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Edgemere</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>2523 Tapes Lane</u>	
3. NAME OF DECEASED (Type or Print) <u>Henry Long</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>12</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OF RACE <u>Caucasian</u>	7. <del>SINGLE</del> , MARRIED, WIDOWED, <del>DIVORCED</del> , (Specify)	8. DATE OF BIRTH <u>April 12<sup>th</sup> 1896</u>
9. AGE last birthday <u>58</u> yrs. <u>54</u> months <u>12</u> days <u>14</u> hours <u>55</u> min.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Steel mills</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Abraham Long</u>	
14. MOTHER'S MAIDEN NAME <u>Emma Johnson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>213-092741</u>		17. INFORMANT AND ADDRESS <u>Dorothy Branch 7815 Parkview Dr Baltimore 17</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

492X

Immediate cause

(a)

Virus Infection

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Hypertension, Arteriosclerosis & enlarged heart

(c)

INTERVAL BETWEEN ONSET AND DEATH

1 Wk.unknown

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input checked="" type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from October 1954, to March 12 1955, that I last saw the deceasedalive on March 1<sup>st</sup> 1955, and that death occurred at 2:15 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION OR ROVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>3-15-55</u>	<u>St. Calvary</u>	<u>Baltimore</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>2-15-55</u>	<u>24. [Signature]</u>	<u>Rayner Sanders</u>	<u>217 E. Preston St, Balto Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2316

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK (22)</u>		LENGTH OF STAY (in this place) <u>29</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK 22</u>		<u>52</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>62 BROADSHIP</u>				STREET ADDRESS (If rural give location) <u>62 BROADSHIP</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>MARY SCANNETT LONG</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>3-13-1955</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH: <u>5 DEC. 1903</u>	
9. AGE last birthday: <u>51</u> yrs.				10. AGE last birthday: If UNDER 1 YEAR, If UNDER 24 HRS. Month: Days: Hours: Min.			
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>W. VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME: <u>ROLFE O. DUVAL</u>			
14. MOTHER'S MAIDEN NAME: <u>EMMA SHEPHER</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk) (If Yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY No.: <u>214-22-8975</u>				17. INFORMANT & ADDRESS: <u>Wm. J. LONG - 62 BROADSHIP</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) <u>MASSIVE Pulmonary Embolism</u>							
Antecedent causes (s) (b) <u>Myocarditis, Chronic</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. <u>Arteriosclerosis</u>							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>3-16-55</u>							
19b. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 8, 1955</u> to <u>March 13, 1955</u> , that I last saw the deceased alive on <u>March 8, 1955</u> , and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE (Degree or title) <u>M. Scannett</u> ADDRESS <u>Dundalk, Md. 3/13/55</u>							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>3-16-55</u>		<u>SACRED HEART</u>		<u>BALTO. CO. MD.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>March 14-1955</u>		<u>Lillian M. Kelly</u>		<u>John P. Bradley</u>		<u>Dundalk, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.

7 16 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02397

2414

## CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH: <u>Spring Grove State Hosp.</u> COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hosp.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Pr. Geo.</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Woodlawn,</u> STREET ADDRESS (If rural give location) <u>6821-68th Avenue</u>	
3. NAME OF DECEASED: (First) <u>Jay</u> (Middle) <u>Bonham</u> (Last) <u>Lord</u> (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH: <u>3</u> <u>22</u> <u>1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>2-17-1890</u>
9. AGE last birthday <u>65</u> yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Retired</u>	
11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>William Lord</u>		14. MOTHER'S MAIDEN NAME: <u>Lottie Bonham</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT & ADDRESS: <u>4821-68th Avenue, Woodlawn.Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>443X</u> Myocardial insufficiency			1 day
ANTECEDENT CAUSE IS: DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO			
STATING UNDERLYING CAUSE LAST. Generalized arteriosclerosis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: _____		19B. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>2/1</u> , 19 <u>55</u> , to <u>3/22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/22</u> , 19 <u>55</u> , and that death occurred at <u>3:15 A. M.</u> from the causes and on the date stated above.			
SIGNATURE <u>S. Wachler</u>		ADDRESS <u>M.D. Spring Grove St. Hospital</u> DATE SIGNED <u>3/22/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>REMOVAL</u>		DATE THEREOF <u>3-22-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Cambria Pa.</u>		LOCATION (City, town, or county) <u>Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-22-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL DIRECTOR <u>Cool &amp; Co</u>		ADDRESS <u>1217 St. Paul St.</u>	



PLEASE TYPE OR WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

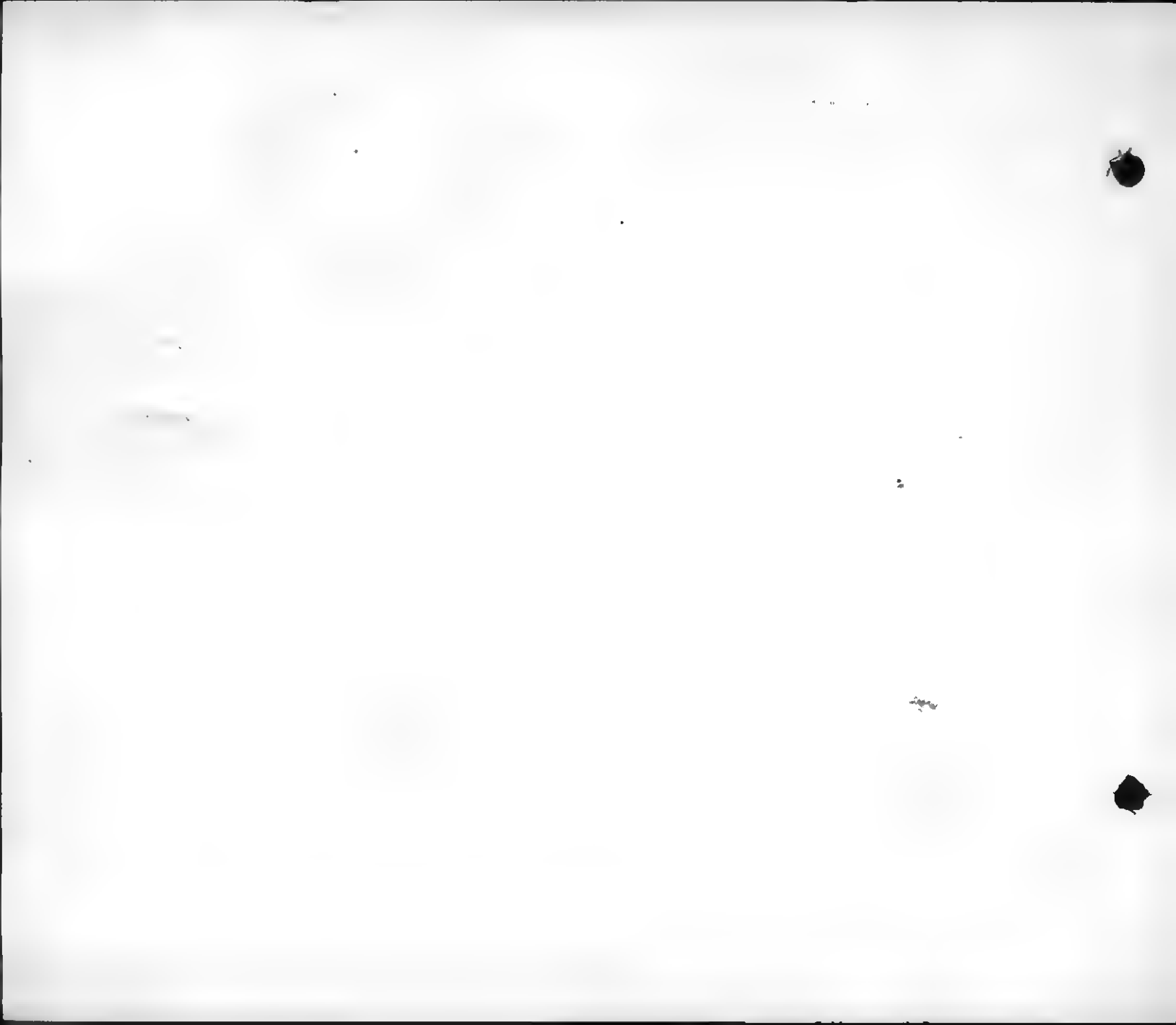
02398

## CERTIFICATE OF DEATH

Reg. Dist. No.

Item 12, File: G179 3-31-55 at

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 TOWN Catonsville</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL, and give nearest town) <u>OR TOWN Baltimore</u>	<u>SV-1-4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>91 1102 N. Rolling Rd. Shady Nook Nursing Home</u>		STREET ADDRESS (If rural give location) <u>20 E. Preston St.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>WILLIAM A. MacGREGOR</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Mar. 21, 1955</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Mar. 11, 1874</u>
		9. AGE last birthday: <u>81</u> yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Accountant (rtd)</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Typewriter Mfr.</u>	
11. BIRTHPLACE (State or foreign country): <u>Woodstock, Can.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Rev. Malcom MacGregor</u>		14. MOTHER'S MAIDEN NAME: <u>Belinda Pavey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Mrs. Nancy Getman-57-51 79th St., Elmhurst</u>		<u>Long Island, N.Y.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>			<u>3 hr</u>
ANTECEDENT CAUSE (B) <u>arterio sclerosis</u>			<u>year</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Myocarditis</u>			<u>years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>June 13, 1954</u> to <u>March 21, 1955</u> that I last saw the deceased alive on <u>March 21, 1955</u> , and that death occurred at <u>13:30</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Loisimke For.</u>		ADDRESS <u>1115 St. Paul St.</u>	
DATE SIGNED		M.D. <u>1115 St. Paul St.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>3/25/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-24-55</u>		REGISTRAR'S SIGNATURE <u>E. W. Hedrick</u>	
24. FUNERAL DIRECTOR <u>Wm. J. Pickner &amp; Sons</u>		ADDRESS <u>Balto., Md.</u>	





02399

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

2416

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1906 THAYER TERRACE</u>		STREET ADDRESS (If rural, give location) <u>1906 THAYER TERRACE</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>ARTHUR S.</u> (Middle) <u>MAULER</u> (Last)	4. DATE OF DEATH (Month) <u>MARCH</u> (Day) <u>14</u> (Year) <u>1955</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M.</u>	8. DATE OF BIRTH <u>FEB. 4 1890</u>
9. AGE last birthday <u>65</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BETHLEHEM STEEL CO. (Retired)</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>CONRAD MAULER</u>		14. MOTHER'S MAIDEN NAME <u>MAY ?</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>I</u>		16. SOCIAL SECURITY NO. <u>MRS. RHODA MAULER 1906 THAYER TERRACE (?)</u>	

## 13. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
491X Immediate cause (a) <u>Terminal Bronchopneumonia</u>		<u>3 days</u>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Heart failure</u>		<u>5 years</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 1, 1953 to Feb. 14, 1955 that I last saw the deceased alive on Mar 14, 1955, and that death occurred at 9 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

L. G. Lally M.D.3517 E. Enderdown CrMar 16 1955

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>3/17/55</u>	<u>BALTIMORE NATIONAL</u>	<u>BALTIMORE</u>	<u>MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3-16-55</u>	<u>Aug. L. Borsall</u>	<u>J.T. STANSBURY</u>	<u>6411 WINDSOR mill RD</u>	

(7)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5 8 1000000

1000000

2417

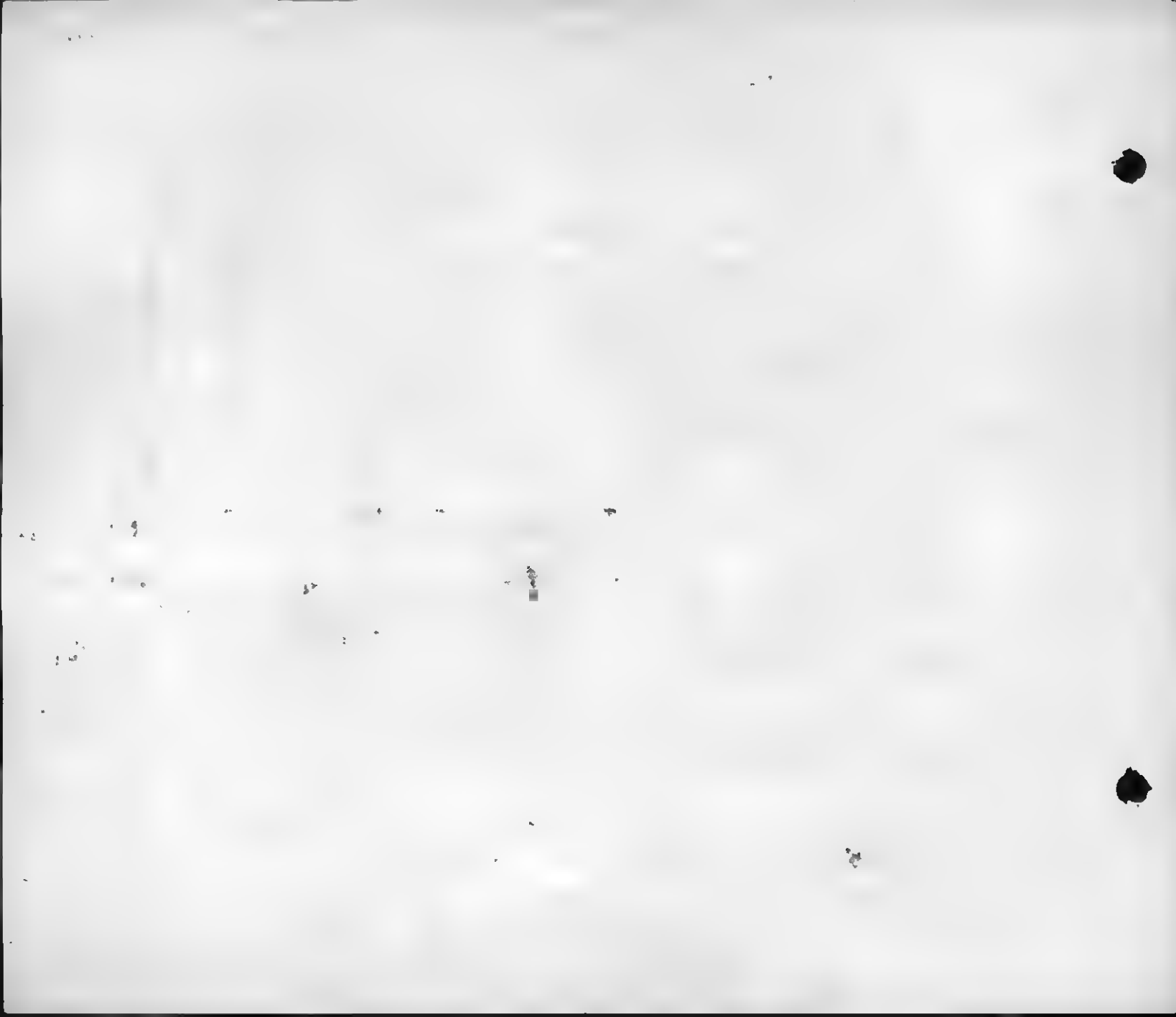
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u> MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BROOKLANDVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BROOKLANDVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VALLEY + JOPPA ROADS</u>		STREET ADDRESS (If rural give location) <u>VALLEY + JOPPA ROADS</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>LILLY CATHERINE MC CAFFEY</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>MAR. 9, 1955</u>	
5. SEX: <u>FEMALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH: <u>FEB. 1, 1865</u>
9. AGE last birthday: <u>90</u> yrs. Months Days Hours Min.		10. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEWIFE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>JOHN A. SOMMERVILLE</u>		14. MOTHER'S MAIDEN NAME: <u>ELLEN CATHERINE FISHER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.): <u>NO</u> (If Yes, give war or dates of service): <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT & ADDRESS: <u>FAMILY RECORDS</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
490X IMMEDIATE CAUSE		10 days	
ANTECEDENT CAUSE (S)		No mos.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		Unk.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
2 I hereby certify that I attended the deceased from <u>2/28</u> , 19 <u>55</u> , to <u>3/9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/8</u> , 19 <u>55</u> , and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Bennett A. D. Owen</u> M.D.		ADDRESS <u>Westminster, Carroll Co., MD.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>MAR. 12, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>		LOCATION (City, town, or county) (State) <u>WESTMINSTER, CARROLL CO., MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3/4/55</u>		REGISTRAR'S SIGNATURE <u>H. H. Henschel</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>John Bennett Owen, Trueman, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2418

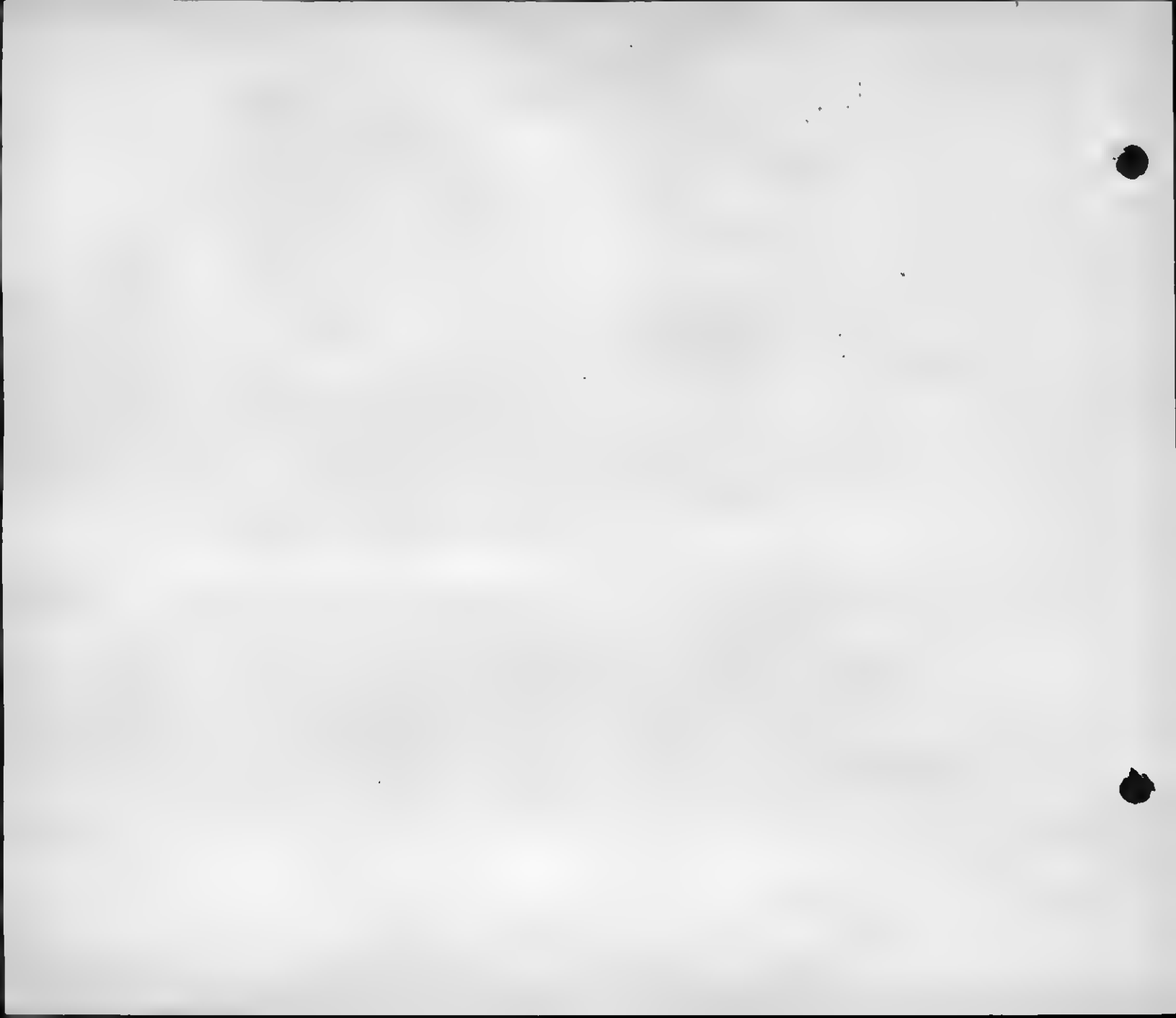
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Calomville</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove St. Hospital</u>				STREET ADDRESS (If rural give location) <u>3406 Walbrook Ave</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>James Samuel McComb</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>3 19 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>11/4/1978</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Watchman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>U.S.F. &amp; G. Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>James McComb</u>				14. MOTHER'S MAIDEN NAME: <u>Susan Mc Dermott</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-07-8120</u>		17. INFORMANT & ADDRESS: <u>Mrs. Marie S. Malone 3406 Walbrook Av.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>570.3 Toxemia and intestinal obstruction</u>						2 days	
ANTECEDENT CAUSE (B) <u>Volvulus of small intestine</u>						2 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>Chronic nephritis</u>						years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 3</u> , 1954, to <u>3/19</u> , 1955, that I last saw the deceased alive on <u>3/19</u> , 1955, and that death occurred at <u>9.00 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>G. Wachser</u>				ADDRESS <u>M.D. Spring Grove St. Hospital</u>		DATE SIGNED <u>3/19/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-22-1955</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		LOCATION (City, town, or county) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-21-55</u>		REGISTRAR'S SIGNATURE <u>4/5</u>		24. FUNERAL DIRECTOR <u>G. Howard Strong</u>		ADDRESS <u>3207 W. North Ave.,</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information correctly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

02401

2419

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>MD.</b> COUNTY <b>A.A.CO.</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>BROOKLYN</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>HOUSE IN THE PINES 16 FUSTING AVE</b>		STREET ADDRESS (If rural, give location) <b>8 W. 2ND AVE BROOKLYN PARK.</b>	
3. NAME OF DECEASED (Type or Print) <b>BYRD</b>	(First) <b>W.</b> (Middle) <b>MC DONALD</b> (Last)	4. DATE OF DEATH <b>MARCH 26</b>	(Month) (Day) (Year) <b>1955</b>
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWER</b>	8. DATE OF BIRTH <b>OCT. 1, 1879</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <b>75</b> yrs.	If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <b>VA.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>STEPHEN D. McDONALD</b>		14. MOTHER'S MAIDEN NAME <b>SIDNEY KEARNS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>578-01-3911</b>	
17. INFORMANT AND ADDRESS <b>MRS EDWIN C. WEAVER, 702 WINANS WAY</b>			

## 13. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4- Immediate cause (a) **Coronary occlusion due to**  
**arteriosclerosis cardiovascular disease**  
 Antecedent cause(s) (b) **myocardial degeneration**  
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

3 1/2

11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.**Bronchopneumonia, severe**

3 days

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **10 Feb.**, 19**52**, to **26 Mar.**, 19**55**, that I last saw the deceased alive on **25 Mar.**, 19**55**, and that death occurred at **3:30 A.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>	DATE THEREOF <b>MAR. 29/55</b>	NAME OF CEMETERY OR CREMATORY <b>GEDAR HILL</b>	LOCATION (City, town, or county) <b>A.A.CO.</b>	(State) <b>MD.</b>
DATE REC'D BY LOCAL REG. <b>3/29/55</b>	REGISTRAR'S SIGNATURE <b>L</b>	24. FUNERAL DIRECTOR <b>Harry H. Witz</b>	ADDRESS <b>4101 EDMONDSON AVE.</b>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2 1





2420  
CERTIFICATE OF DEATH

Reg. Dist. No. 7

## 1. PLACE OF DEATH:

Baltimore

COUNTY

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)  
TOWSONLENGTH OF STAY  
(in this place)HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Presbyterian Home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md.

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)  
OR TOWN Baltimore 2001-4STREET  
ADDRESS

4315 Garrison Ave.

3. NAME OF  
DECEASED:

(First)

(Middle)

(Last)

Susanna Jamison McLean

4. DATE

(Month)

(Day)

(Year)

OF  
DEATH: March 10, 19 555. SEX:  
Female6. COLOR OR  
WHITE7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify): single

8. DATE OF BIRTH:

May 13, 1870

9. AGE last birthday:

84

IF UNDER 1 YEAR IF UNDER 24 HRS.  
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired): retired credit manager of Dept. store10b. KIND OF BUSINESS OR  
INDUSTRY: Baltimore, Md.12. CITIZEN OF WHAT  
COUNTRY:

## 13. FATHER'S NAME:

John J. McLean

## 14. MOTHER'S MAIDEN NAME:

Rose

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

Records-Presbyterian Home Towson, Md.

## 15. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

442X  
Immediate cause

(a) DUE TO

Cardio-Renal-Vascular disease

Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating underlying cause last

(b) DUE TO

Senile changes  
Arteriosclerosis

(c)

INTERVAL BETWEEN  
ONSET AND DEATH

44 yrs +

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

## 20. AUTOPSY:

Yes ☐ No ☒21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURYINJURY OCCURRED  
While at Not while  
work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1951, to March 1955, that I last saw the deceased  
alive on 3/13, 1955, and that death occurred at 1:30 P.M., from the causes and on the date stated above.  
SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED  
Rollie L. Hudson M.D. Towson 4 Md 3/11/5523. BURIAL, CREMATION  
REMOVAL (Specify):

Burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

March 14, 1955 Woodlawn

Woodlawn, Md.

DATE REC'D BY LOCAL  
REG.

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

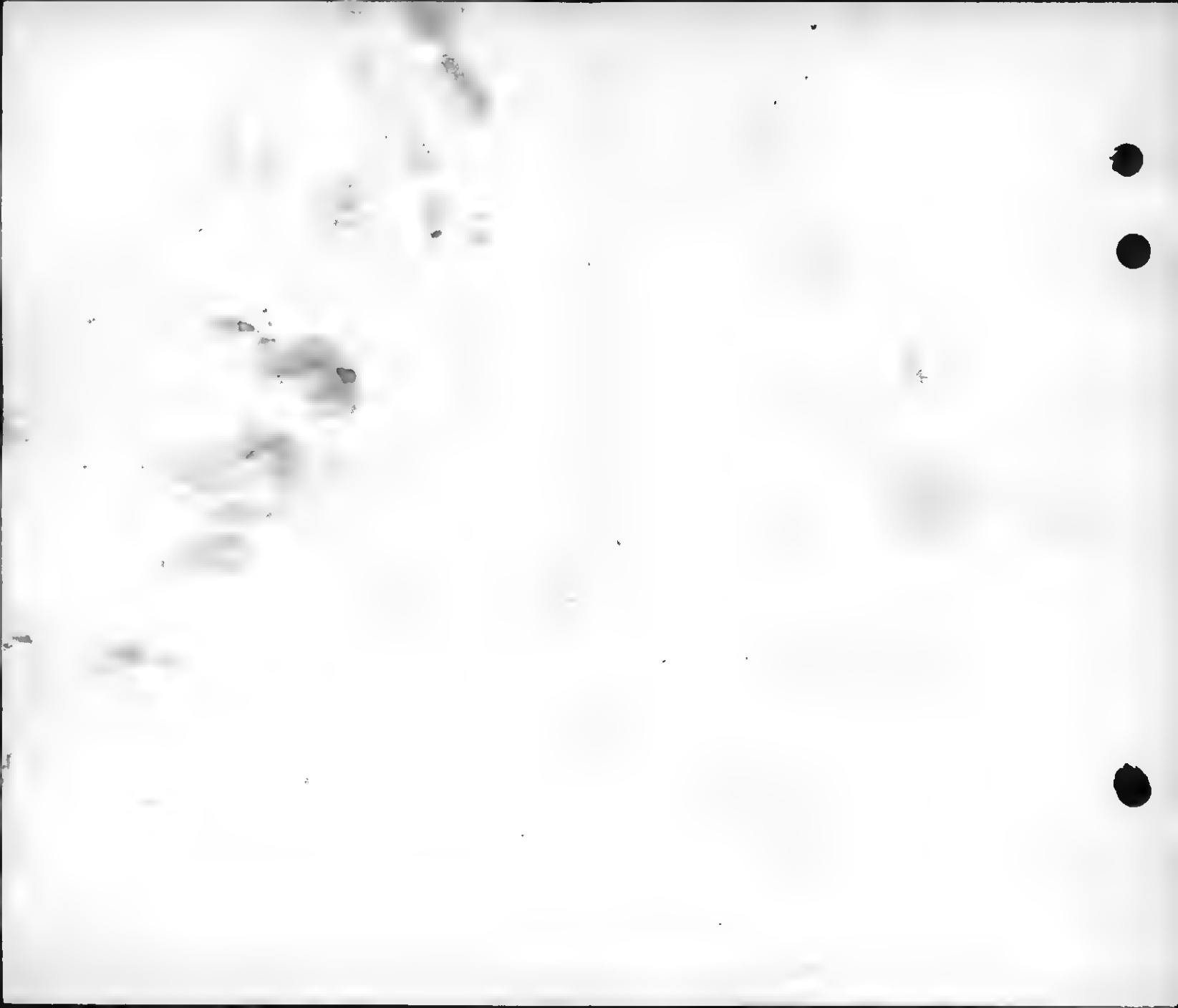
ADDRESS

MAR 12 1955

John O. Mitchell &amp; Sons Inc.

1900 Eutaw Place

MARGIN RESERVED FOR BINDING



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02403  
2421 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>52 TOWN</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL OR TOWN <u>Baltimore</u>		3y 1-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Paradise Nursing Home</u>				STREET ADDRESS (If rural give location) <u>327 S. Payson St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Julia</u> <u>McSweeney</u>				<u>Mar.</u> <u>7</u> <u>1955</u>			
5. SEX: <u>female</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>Mar. 20, 1876</u>	
9. AGE last birthday: <u>78</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY: <u>housemistress</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Daniel McSweeney</u>				14. MOTHER'S MAIDEN NAME: <u>Hannah Eney</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO.: <u>212-61-6008</u>		17. INFORMANT & ADDRESS: <u>Mrs. J. Burk Little 724 Edgewood St.</u>			
18. MEDICAL CERTIFICATION							Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 Immediate cause (a) <u>Cardiac Arrhythmia</u>							4 mos.
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vascular Disease</u>							10 yrs.
(c)							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION							20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 1, 1947</u> , to <u>March 7, 1955</u> , that I last saw the deceased alive on <u>March 6, 1955</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William E. Leonard, M.D.</u>				DATE SIGNED <u>Mar. 10, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>buried</u>		<u>Mar. 10, 1955</u>		<u>Western Cemetery</u>		<u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3/9/55</u>		REGISTRAR'S SIGNATURE <u>W. E. Leonard</u>		24. FUNERAL DIRECTOR <u>R. B. Murphy</u>		ADDRESS <u>1301 Eastern Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

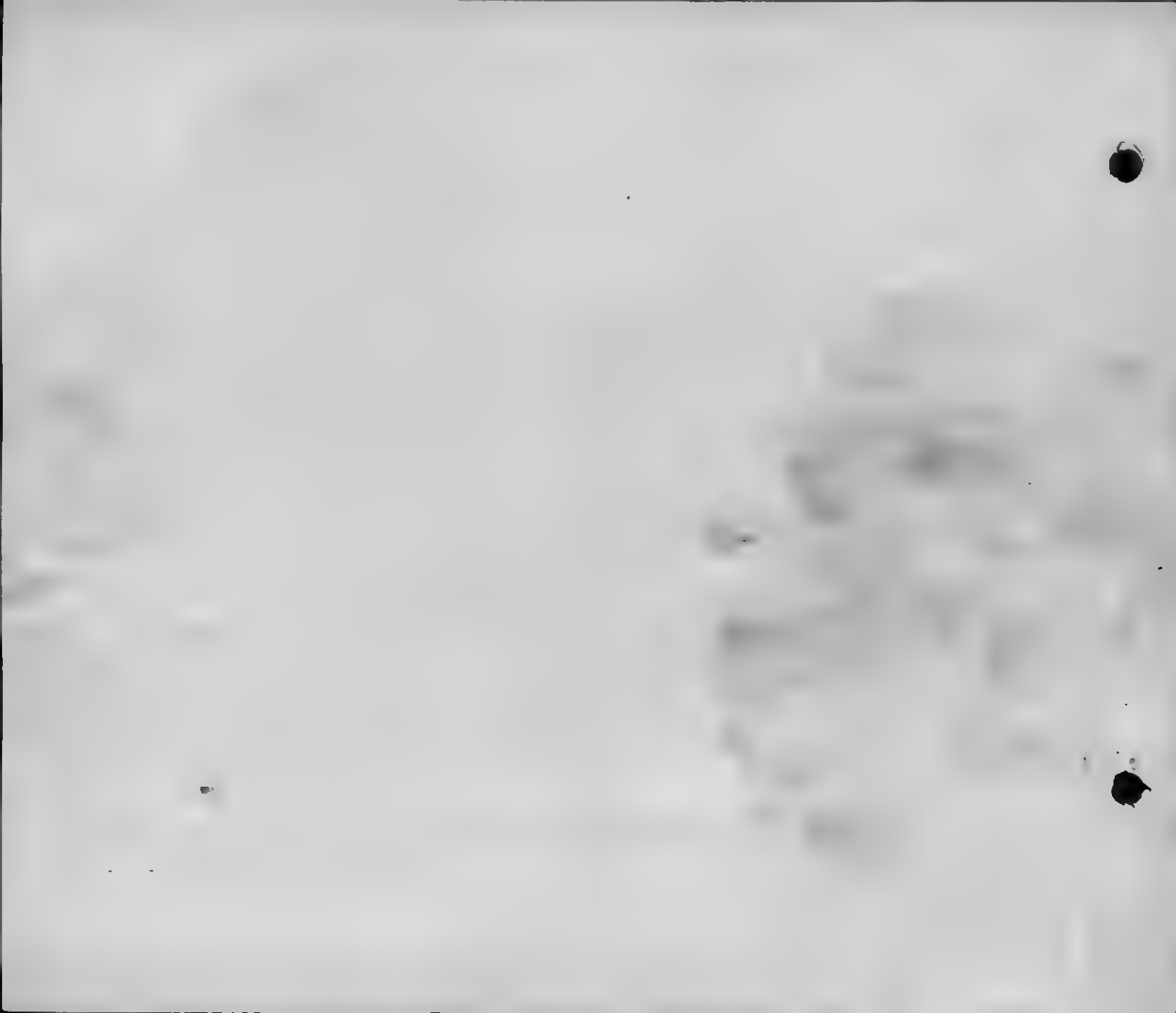


2422  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 Reg. 12404  
 No. ....

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Baltimore		STATE	Maryland COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		
52 TOWN Catonsville	3mo. 8 days		TOWN Baltimore	C 2 X 2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital			STREET ADDRESS (If rural, give location) 302 Riverside Road		
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First)	(Middle)	(Last)	(Month)	(Day)	(Year)
Howard	Milton	Miller	March	11	19 55
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.
Male	White	Married	6-15-1903	51 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Glass worker - Swindell Co.			11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Albert Miller			14. MOTHER'S MAIDEN NAME: Sophia Kaisier		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes			16. SOCIAL SECURITY No.: Unknown		
17. INFORMANT & ADDRESS: Records Spring Grove State Hospital					

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
231x Immediate cause (a) Congestive heart failure DUE TO					
Antecedent cause(s) (b) due to Mediastinal tumor or growth					
Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town, (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE: Geo. McKieffer		1010 Leads or		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3-11-55 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE WHEREOF 3/16/55		NAME OF CEMETERY OR CREMATORY Baltimore Nat.	
LOCATION (City, town, or county) (State) Baltimore		24. FUNERAL DIRECTOR James L. McCully - 130 E. Fort Ave.		ADDRESS	
DATE RECD BY LOCAL REG. 3-11-55		REGISTRAR'S SIGNATURE			



02405

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 45

2423

1. PLACE OF DEATH COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Middle River</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Middle River</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>18 Cockpit St.</u>		STREET ADDRESS (If rural give location) <u>18 Cockpit St</u>	
3. NAME OF DECEASED (Type or Print) <u>Phoebe</u>	(First) <u>M.</u> (Middle) <u>Miller</u> (Last)	4. DATE OF DEATH (Month) <u>3</u> (Day) <u>2</u> (Year) <u>1953</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>12/23/1869</u>
9. AGE last birthday <u>85</u> yrs.		10. AGE last birthday If under 1 year (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Battorf</u>		14. MOTHER'S MAIDEN NAME <u>Jane Bateman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Foster Miller</u>		<u>18 Cockpit St.</u>	

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Cardiac arrest</u>		
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>arterio-sclerotic cerebrovascular disease</u>		
(c) <u>arterio-sclerotic cerebrovascular disease</u>		<u>2 day</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>20 yrs</u>

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June, 1953, to March 2, 1955, that I last saw the deceased alive on March 2, 1955, and that death occurred at 10:45 P.m., from the causes and on the date stated above.

SIGNATURE <u>Lois Semeroff</u>	(Degree or title) <u>MD</u>	ADDRESS <u>1437 Tulelog Ave, Balto 20, Md</u>	DATE SIGNED <u>3/2/55</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>3.5.55</u>	NAME OF CEMETERY OR CREMATORY <u>GRAVE GARDVIEW CEM.</u>	LOCATION (City, town, or county) (State) <u>PENNA.</u>
DATE REC'D BY LOCAL REG. <u>3/2/55</u>	REGISTRAR'S SIGNATURE <u>Said Hurley</u>	24. FUNERAL DIRECTOR <u>Sassahon Funeral Home?</u>	ADDRESS <u>7401 Belair Rd</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V.

MAR 11 3

6-50-100



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2424

### CERTIFICATE OF DEATH

02406

Reg. Dist. No. *XX*

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>X</i> TOWN <u>Fort Howard</u>		LENGTH OF STAY (In this place) <u>2 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>3743 Nortonia Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>FRANK H. MILLS</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>March 13</u> <u>1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>2/27/92</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Stationary</u>		11. BIRTHPLACE (State or foreign country): <u>New York, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Frank D Mills</u>				14. MOTHER'S MAIDEN NAME: <u>May R. Hodgkins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW-II</u>				16. SOCIAL SECURITY NO. <u>212 16 2212</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						2 Weeks	
IMMEDIATE CAUSE (A) <u>CEREBROVASCULAR ACCIDENT</u>							
ANTECEDENT CAUSE (B) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Mar. 11, 1955, to Mar. 13, 1955, that I last saw the deceased <u>March 13, 1955</u> and that death occurred at 1:10AM, from the causes and on the date stated above.							
SIGNATURE <u>C. Gonzalez, M.D.</u>		ADDRESS <u>VAH, Fort Howard, Md.</u>		DATE SIGNED <u>3/13/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-16-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-15-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Howard G. STRONG Funeral Home</u>		ADDRESS <u>3207 W. North Ave. Baltimore, Md.</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

2425

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

02407

44

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Baltimore</u> -19 <u>MARYLAND</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>...</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sparrows Pt</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>...</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1311 Sparrows Pt. Rd.</u>		STREET ADDRESS <u>...</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>STEVE</u> (First) <u>MIMIDIS</u> (Middle) <u>MIMIDIS</u> (Last)		4. DATE OF DEATH <u>Mar. 24, 1955</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH <u>Aug. 6, 1896</u>
9. AGE last birthday <u>58</u> yrs.		10. AGE last birthday If under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tavern owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tavern</u>	
11. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Mimidis</u>		14. MOTHER'S MAIDEN NAME <u>Ardue. (last name unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>...</u>	
17. INFORMANT AND ADDRESS <u>Nagle Mimidis wife. address. as in #1.</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

141 Immediate cause (a)...

Antecedent cause(s) (b)...

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED While at Work Not While At work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug., 1932, to Mar 24, 1955, that I last saw the deceased

alive on Mar 23, 1955, and that death occurred at 11: A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Lois N. Hollen, M.D. 6908 North Pt Rd. Balto. 19- 3/24/55

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

March 26-55

Dawson L. Harber

Ullrich Funeral Home 2112 Dundas Ave

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 23 1971

RECEIVED

02408

2426

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 449

1. PLACE OF DEATH - COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Sparrows Point		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Sparrows Point 19	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Bethlehem Steel Plant		STREET ADDRESS 1018 H Street	
3. NAME OF DECEASED (First) PAUL (Middle) Wilbur (Last) Morris		4. DATE OF DEATH March 21, 1955 19	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Sept. 13 1900 54 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY Steel	11. BIRTHPLACE (State or foreign country) Pennsylvania
13. FATHER'S NAME Thomas Morris		14. MOTHER'S MAIDEN NAME Alice Ritz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. 213-07-1042	17. INFORMANT AND ADDRESS Grace Morris Sparrows Pt. 19, Md.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause

(a)

Coronary Occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED 3/21/55

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF 3/25/55

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

March 23-55

Lawson L. Harbo

Walter Branch Bradley, Inc.

Dundalk 22

Maryland

MARGIN RESERVED FOR BINDING

VS. A15A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V.

MAR 2

RECEIVED

2427

## MARYLAND STATE DEPARTMENT OF HEALTH

02409

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Codd Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>2903 E. Baltimore St. v</u>	
3. NAME OF DECEASED (Type or Print) <u>JOSEPH</u>	(First) <u>H.</u> (Middle)	(Last) <u>MULLEN SR.</u>	4. DATE OF DEATH <u>MARCH 25</u> 19 <u>55</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Sept. 27, 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TUGBOAT CAPTAIN (RETIRED)</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>81</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Mins.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Gregory Mullen</u>		14. MOTHER'S MAIDEN NAME <u>Mary Donnelly</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Herbert Mullen - 2822 E. Baltimore St.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from March 16, 1955 to March 25, 1955, that I last saw the deceasedalive on March 22, 1955, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Mar. 28, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>	LOCATION (City, town, or county) <u>Baltimore, Md</u>	(State)
DATE REC'D BY LOCAL REG. <u>MAR 28 1955</u>	REGISTRAR'S SIGNATURE <u>Mark Gray</u>	24. FUNERAL DIRECTOR <u>John A. Moran</u>	ADDRESS <u>3000 E. Baltimore St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

RECEIVED



2428

## CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Baltimore</u> MARYLAND			STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u> LENGTH OF STAY (in this place)			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u> 5		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6614 Loch River Blvd.</u>			STREET ADDRESS (If rural give location) <u>6614 Loch River Blvd.</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>JOHN</u> <u>ARCHER</u> <u>MURRAY, JR.</u>			4. DATE OF DEATH: (Month) (Day) (Year) <u>March</u> <u>10</u> <u>1955</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>3-17-27, 1917</u>		
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Attendant</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>Service Station</u>		
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME: <u>John Archer Murray</u>			14. MOTHER'S MAIDEN NAME: <u>Elizabeth Hiser</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u> <u>None</u>			16. SOCIAL SECURITY No.: <u>212-18-7900</u>		
17. INFORMANT & ADDRESS: <u>John A. Murray, 6614 Loch River Blvd., Towson</u>					

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death <u>6 months</u>
Immediate cause (a) <u>Carcinoma, Bronchogenic (Smog)</u>		
Antecedent causes (s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.</u>		
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
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19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Nov, 1954, to 10 March, 1955, that I last saw the deceased alive on 10 March, 1955, and that death occurred at 1 A.M., from the causes and on the date stated above.

23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>12-21</u>		<u>Mar. 10, 1955</u>		<u>Druid Ridge Cemetery</u>		<u>Pikesville, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Mar. 12, 1955</u>		<u>Mabel C. Gray</u>		<u>John Burns, Sr.</u>		<u>Towson, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1000

1000

2429

## CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>BALTIMORE</b>		MARYLAND		STATE <b>MARYLAND</b> COUNTY <b>BALTIMORE</b>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <b>TOWSON 4</b>				OR TOWN <b>TOWSON 4</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>821 WELLINGTON RD.</b>				STREET ADDRESS (If rural give location) <b>821 WELLINGTON ROAD</b>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<b>JOSEPH HOWARD MURRAY</b>				OF DEATH: <b>MAR. 18, 1955</b>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS	
<b>MALE</b>	<b>WHITE</b>	<b>MARRIED</b>	<b>AUG. 2, 1898</b>	<b>56</b> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>CHIEF JUDGE</b>		<b>CIRCUIT COURT</b>		<b>MARYLAND</b>		<b>USA</b>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<b>JOSEPH B. MURRAY</b>				<b>HELEN MURRAY</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<b>NO</b>				<b>NONE</b>		<b>FAMILY RECORDS</b>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Congestive Heart Failure</b>						<b>13 months</b>	
ANTECEDENT CAUSE (B) <b>Old Rheumatic &amp; Coronary disease</b>						<b>10 yrs</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<b>Ventricular Fibrillation</b>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
2 I hereby certify that I attended the deceased from <b>1945</b> to <b>Mar.</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>3/11</b> , 19 <b>55</b> , and that death occurred at <b>8:45 P.M.</b> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<b>For A. Sealack</b>		<b>M. D. 200 W. Penna. Ave Towson</b>		<b>3/21/55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>MAR. 21, 1955</b>		<b>PROSPECT HILL CEM. TOWSON, MD.</b>			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		4. JUNE 2 DIRECTOR		ADDRESS	
<b>Mar. 21, 1955</b>		<b>Mark C. Gray</b>		<b>John Burne Love, Towson, Md.</b>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

INVENTORY # 1

1981

1981

2430

## CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 PLACE OF DEATH:		2 USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u> MARYLAND		STATE <u>MD</u> COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ROCKDALE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ROCKDALE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3604 TULSA RD</u>		STREET ADDRESS (If rural give location) <u>3604 TULSA ROAD</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>MARY E. NEAL</u>		OF DEATH: <u>9</u> <u>13</u> <u>1955</u>	
5 SEX: <u>FEMALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOW</u>	8. DATE OF BIRTH: <u>12-24-1867</u>
9. AGE last birthday: <u>87</u> yrs		10. MONTHS: <u>8</u> DAYS: <u>13</u> HOURS: <u>19</u> MIN.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>HEROME N. B. DAYTON</u>		14. MOTHER'S MAIDEN NAME: <u>HARRIETT CANNON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: <u>NONE</u>	
17. INFORMANT & ADDRESS: <u>MARY N. MORITZ 306 S. CALHOUN ST</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
4427 IMMEDIATE CAUSE (A) <u>Cardiovascular renal disease</u>			
ANTECEDENT CAUSE (S) (B) <u>Generalized arterio sclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>9/1</u> , 19 <u>55</u> to <u>3/13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/12</u> , 19 <u>55</u> , and that death occurred at <u>830 P.</u> M. from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		ADDRESS <u>4710 Liberty Ave</u> DATE SIGNED <u>3/15/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>BURIAL</u>		DATE THEREOF <u>3-16-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>HARRAINE CEM</u>		LOCATION (City, town, or county) <u>WOODLAWN, MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL DIRECTOR <u>[Signature]</u>			

MARGIN RESERVED FOR BINDING



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02414

2432

## CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Balti. re</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		X	
X TOWN <u>Overlea</u>				STREET ADDRESS		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>8 East Overlea Avenue</u>		<u>8 East Overlea Avenue #6</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>Mr. John Henry Nolker</u>				OF DEATH: <u>MARCH 10th 1955</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>married</u>		8. DATE OF BIRTH: <u>Aug. 1, 1886</u>	
9. AGE last birthday <u>68</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>		11. CITIZEN OF WHAT COUNTRY? <u>USA</u>		12. IF UNDER 1 YEAR: Months Days Hours Min.	
13. FATHER'S NAME: <u>Henry Nolker</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Kramer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS: <u>Mrs. Mary E. Nolker, 8 E. Overlea Ave. #6</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Congestive failure</u>						<u>2 days</u>	
ANTECEDENT CAUSE (B) <u>Coronary artery disease</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>arteriosclerotic</u>						<u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>chr. cholecystitis + stones</u>						<u>3-4 yrs</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>18 March, 1954</u> , to <u>16 March, 1955</u> , that I last saw the deceased alive on <u>10 March</u> , 1955, and that death occurred at <u>5:47 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Samuel L. Schenck</u>		M.D. <u>7142 Preston St</u>		DATE SIGNED <u>11 March 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar. 15, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, ar land</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-11-55</u>		REGISTRAR'S SIGNATURE <u>R W Pedunk</u>		24. FUNERAL DIRECTOR <u>Leonard J. Buck</u>		ADDRESS <u>6305 Harford Road #14</u>	

Dr. Lilienfeld  
714 E. Preston Street  
6 - 8 Thursday  
9 - 10 Friday.



2431

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Hampstead Rural</u>		<u>10 yrs</u>		OR TOWN <u>Hampstead Rural</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Upper Brehmerville Rd</u>				STREET ADDRESS (If rural, give location) <u>Upper Brehmerville Rd</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) <u>Gladie</u>		(Middle) <u>M</u>		(Last) <u>Nichols</u>		(Month) (Day) (Year) <u>March 28 1955</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>March 11 1907</u>	
						9. AGE last birthday: <u>48</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME: <u>James J. Lambert</u>				14. MOTHER'S MAIDEN NAME: <u>Lucie Albarr</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No.: <u>217-01-6468</u>		17. INFORMANT & ADDRESS: <u>Andrew Nichols Jr. Hampstead Md</u>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
153X Immediate cause (a) <u>Generalized Carcinomatosis</u>				6 mo	
Antecedent cause(s) (b) <u>Primary Carcinoma of Cervix</u>				2 yrs.	
(c)					
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION: <u>Aug 1953</u>				19b. MAJOR FINDINGS OF OPERATION: <u>Primary Carcinoma of Cervix</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, or office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Aug 1953</u> to <u>March 28 1955</u> , that I last saw the deceased alive on <u>March 26</u> , 19 <u>55</u> , and that death occurred at <u>12:45 P.M.</u> , from the causes and on the date stated above.					
SIGNATURE <u>Joseph E. Bush</u>		(DEGREE OR TITLE) <u>M.D.</u>		ADDRESS <u>Hampstead Md</u>	
DATE SIGNED <u>3/28/55</u>					
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>		DATE TAKEN <u>Mar 30/55</u>		NAME OF CEMETERY OR CREMATORY <u>Grave Run</u>	
LOCATION (City, town, or county) <u>Baltimore</u>					
DATE REC'D BY LOCAL REG. <u>3-30-55</u>		REGISTRAR'S SIGNATURE <u>Mary B. Zline</u>		24. FUNERAL DIRECTOR <u>Edw. A. Tipton</u>	
				ADDRESS <u>Hampstead Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DUNN V. S.

APR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2433 CERTIFICATE OF DEATH

02415

Reg. Dist. No.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>md</u> COUNTY <u>Balt.</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Essey</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Essey</u>		<u>54</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>60</u>				STREET ADDRESS (If rural, give location) <u>209 Eastern Blvd.</u>		<u>1</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>William Frederick Norton</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>3-28-1955</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>married</u>	8. DATE OF BIRTH: <u>2-16-1910</u>	9. AGE last birthday: <u>45</u> yrs.	IF UNDER 1 YEAR: Months <u>1</u> Days <u>12</u>	IF UNDER 24 HRS. Hours <u>12</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country): <u>Georgia</u>	
13. FATHER'S NAME: <u>Fred. W. Norton</u>				14. MOTHER'S MAIDEN NAME: <u>Bessie L. Knight</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>213-07-4269</u>				17. INFORMANT & ADDRESS: <u>Sarah Eliz. Norton (Wife) Above</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:	INTERVAL BETWEEN ONSET AND DEATH
416X Immediate cause (a) DUE TO <u>Coronary Occlusion</u>	<u>instant</u>
Antecedent cause(s) (b) DUE TO <u>Rheumatic Heart Disease</u>	<u>6 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)	

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from March 19, 1955, to March 28, 1955, that I last saw the deceased alive on Jan 15, 1955, and that death occurred at 3:35 P m., from the causes and on the date stated above.

SIGNATURE <u>Joseph Meale MD</u>	(DEGREE OR TITLE)	ADDRESS <u>423 Eastern Ave Essey Md</u>	DATE SIGNED <u>3/29/55</u>
23. BURIAL, CREMATION REMOVAL (Specify): <u>burial</u>	DATE THEREOF <u>4-1-55</u>	NAME OF CEMETERY OR CREMATORY <u>Gayton Cemetery</u>	LOCATION (City, town, or county) (State) <u>Gayton Georgia</u>
DATE REC'D BY LOCAL REG. <u>3-30-55</u>	REGISTRAR'S SIGNATURE <u>W. H. Hedrick</u>	24. FUNERAL DIRECTOR <u>John S. Connelley Essey</u>	ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02416

2434

## CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>md.</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Middle River, Md.</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Balto.</u>	<u>3 1/2</u> - <u>4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>19 Harrison Ave.</u>		STREET ADDRESS (If rural give location) <u>516 South Lugerne Ave. 24 Md.</u>	
3. NAME OF DECEASED: (Type or Print)	(First) <u>Aniela</u>	(Middle) <u>Macioch</u>	(Last) <u>Oknaiski</u>
4. DATE OF DEATH: (Month) <u>Mar.</u> (Day) <u>3</u> (Year) <u>1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>Sept 17-1884</u>
9. AGE last birthday <u>70</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife Retired</u>	11. BIRTHPLACE (State or foreign country): <u>Poland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME: <u>Nicholas Malinowski</u>	14. MOTHER'S MAIDEN NAME: <u>Teofila Mathieski</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>215-03-20830A</u>	17. INFORMANT & ADDRESS: <u>Christine Brudzinski - 1407 Eastern Ave.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Metastatic Carcinoma</u>		<u>6 mo</u>	
ANTECEDENT CAUSE (B) <u>Carcinoma of colon</u>		<u>18 mo</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>Sept 14, 1954</u>	19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of colon</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 15, 1955</u> , to <u>Mar 3, 1955</u> , that I last saw the deceased alive on <u>Mar 2, 1955</u> , and that death occurred at <u>10:10 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Joseph Macioch</u>		ADDRESS <u>M.D. 423 Eastern Ave East 21</u> DATE SIGNED <u>3/3/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>3-7-55</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cemetery</u>	LOCATION (City, town, or county) (State) <u>Balto Co</u>
DATE REC'D BY LOCAL REGISTRAR <u>3-4-55</u>	REGISTRAR'S SIGNATURE <u>A W Hedberg</u>	FUNERAL DIRECTOR <u>Brudzinski</u> ADDRESS <u>1407 Eastern Ave</u>	

MARGIN RESERVED FOR BINDING

VS. A15 - 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

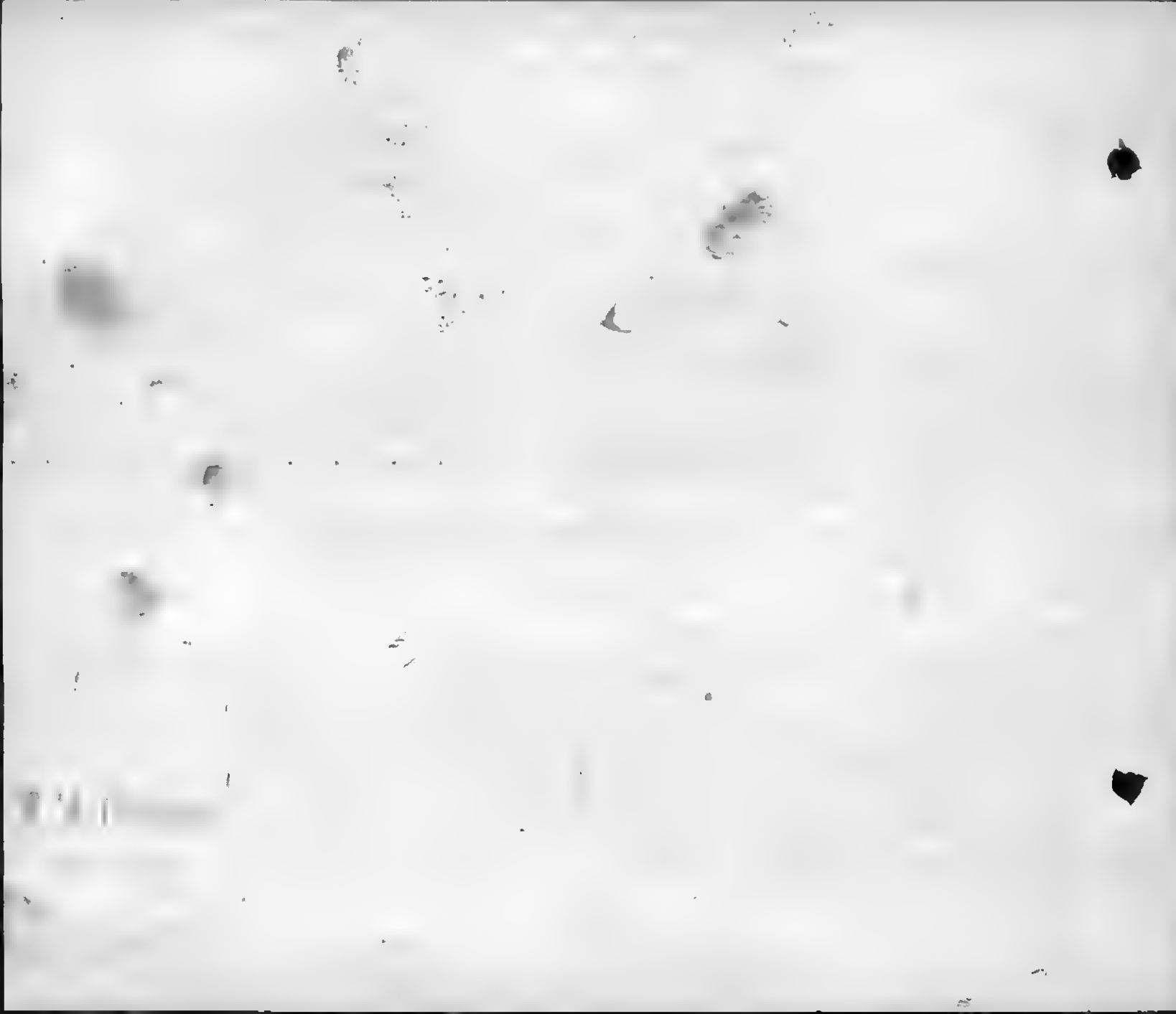
02417

2435

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Baltimore</u> MARYLAND			STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>		
CITY (If outside corporate limits, write RURAL or and give nearest town) X TOWN <u>Fort Howard</u>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u> <u>62-11-2</u>		
HOSPITAL OR INSTITUTE OR STREET ADDRESS <u>Veterans Administration Hospital</u>			STREET ADDRESS (If rural give location) <u>3 Carroll Street</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>CHARLES A. OLIVER</u>			4. DATE OF DEATH: (Month) (Day) (Year) <u>March 18, 1955</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>January 14, 1879</u>		9. AGE last birthday <u>76</u> yrs.   IF UNDER 1 YEAR: Months   Days   IF UNDER 24 HRS.: Hours   Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if <u>Building Attendant</u> )		10B. KIND OF BUSINESS OR INDUSTRY: <u>Federal Government</u>		11. BIRTHPLACE (State or foreign country): <u>Annapolis, Maryland.</u>	
13. FATHER'S NAME: <u>Arthur Oliver</u>			14. MOTHER'S MAIDEN NAME: <u>Rachel MN: Watkins</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) <u>Yes</u> <u>WW-I</u>			16. SOCIAL SECURITY NO. <u>215-22-2498</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hospital, Fort Howard, Md.</u>
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					UNKNOWN
IMMEDIATE CAUSE (A) <u>SENILITY AND DIABETES MELLITUS</u>					
ANTECEDENT CAUSE (B) <u>DUE TO</u>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>DUE TO</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>POST OPERATIVE SHOCK</u>					2 DAYS
19A. DATE OF OPERATION: <u>3-16-55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Above Knee Amputation, Left leg</u>			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>VA</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Mar. 8, 1955, to March 18, 1955, and that death occurred at 9:50 PM, from the causes and on the date stated above.</u>					
SIGNATURE <u>William B. Vandegrift, M.D.</u>		ADDRESS <u>M. D. VAH, Fort Howard, Md.</u>		DATE SIGNED <u>3-19-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/22/1955</u>		NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State) <u>Annapolis National Cem. Annapolis, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>March 21, 1955</u>		REGISTRAR'S SIGNATURE <u>Raymond L. Farkes</u>		24. FUNERAL DIRECTOR ADDRESS <u>Ethel Hicks Funeral Home, 43-45 Northwest Street, Annapolis, Maryland</u>	





02418

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2436

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Baltimore</u>		MARYLAND	STATE <u>Maryland</u> COUNTY		
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fort Howard</u>		LENGTH OF STAY (In this place) <u>2 Days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>1822 N. Register St.,</u>			
3. NAME OF DECEASED: (Type or Print) <u>WESLEY</u>			4. DATE (Month) (Day) (Year) OF DEATH <u>March 10 1955</u>		
(First) (Middle) (Last)					
<u>PAYNE</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>11/25/87</u>		9. AGE last birthday <u>67</u> yrs
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Construction</u>		11. BIRTHPLACE (State or foreign country): <u>Washington, D. C.</u>	
13. FATHER'S NAME: <u>Unknown</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
14. MOTHER'S MAIDEN NAME: <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>212-12-1966</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>	
(If Yes, give war or dates of service) <u>WW I</u>					
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE (A) <u>CEREBRO-VASCULAR ACCIDENT</u>					<u>10 DAYS</u>
ANTECEDENT CAUSE (B) <u>DUE TO HYPERTENSION, ESSENTIAL</u>					<u>UNKNOWN</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.					<u>UNKNOWN</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>LUES PNEUMONITIS</u>					<u>TERMINAL</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Mar. 8, 1955</u> , to <u>Mar. 10, 1955</u> , and that death occurred at <u>5:45 PM</u> from the causes and on the date stated above.					
SIGNATURE <u>Francis G. Dickey</u>		ADDRESS <u>M.D. Chief, Medical Service, VAH, Fort Howard, Md.</u>		DATE SIGNED <u>3-11-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-13-55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	
LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		24. FUNERAL DIRECTOR <u>Rayner Sanders Funeral Home</u>		ADDRESS <u>217 E. Preston Street, Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-15-55</u>		REGISTRAR'S SIGNATURE <u>A. A. Hedrick</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2437

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Mass.</i> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <i>Cockeysville Md</i>		<i>2 yrs</i>		TOWN <i>Pittsfield Mass.</i>		<i>28X-3</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Masonic Home</i>				STREET ADDRESS (If rural give location) <i>Narragansett Ave</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<i>William Redgrove Perine</i>				<i>Mar. 29 1955</i>			
5. SEX: <i>Male</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH: <i>Jan. 9-1865</i>	
						9. AGE last birthday: <i>90</i> yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country):	
<i>Night Watchman</i>				<i>Permon &amp; Klein</i>		<i>Baltimore Md</i>	
12. FATHER'S NAME: <i>Wm. H. Perine</i>				14. MOTHER'S MAIDEN NAME: <i>Emma C. Evans</i>			
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No. <i>212-16-04562</i>		17. INFORMANT & ADDRESS: <i>Laura M. Schroeder</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
443X IMMEDIATE CAUSE (A) <i>Hypertensive Arterio sclerosis</i>						<i>over 2 yrs</i>	
ANTECEDENT CAUSE (B) <i>Vascular disease</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>and Bronchitis</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While at work Not while at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>4-8-1955</i> , to <i>Mar. 29, 1955</i> , that I last saw the deceased alive on <i>Mar. 29, 1955</i> , and that death occurred at <i>4:50 P. M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Walter J. Kus</i>				ADDRESS <i>M. D. Cockeysville Md</i>		DATE SIGNED <i>30 March 1955</i>	
23. BURIAL, CREMATION, REMOVAL (Specify)				NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>4/1/55</i>				<i>Lorraine Cemetery</i>		<i>Balto. Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>3/29/55</i>				REGISTRAR'S SIGNATURE <i>L.M. Schroeder</i>		24. FUNERAL DIRECTOR: <i>Wm. Cook, St. Paul &amp; Preston St</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
U. S. DEPT. OF JUSTICE

APR 1 1945

RECEIVED  
U. S. DEPT. OF JUSTICE

## CERTIFICATE OF DEATH

STATE OF MARYLAND

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

2438 Josephine C. Peters

2. DATE  
OF  
DEATH

3/7/55

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore Co.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR INSTITUTION location)Daughters of the  
Catholic Eucharist Home 30

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

3Y01-4

D. STREET ADDRESS (If rural, give location)

1124 Scott St.

C. Length of stay in Baltimore

Life

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

1/2/1881

9. AGE (In years

last birthday)

74

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Mins.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

House work

10B. KIND OF BUSINESS OR  
INDUSTRY

at Home

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John M. Neubert

14. MOTHER'S MAIDEN NAME

Anna Lambert

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mrs Marie C. B. Lottenberger

ADDRESS

11185

18. 423.0

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

arteriosclerotic Heart Disease

INTERVAL BETWEEN  
ONSET AND DEATH

unknown

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

coronary occlusion

1 Hour

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Diabetes mellitus

unknown

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 15 1952 to  
March 7 1955, that (I) (we) last saw the deceased alive on March 6 1955,  
and that death occurred at 1:20 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Nathan

Rosen

MED. DIRECTOR ☐STAFF PHYS. ☐

23B. ADDRESS

206 S. Gilman St.

23C. DATE SIGNED

3-7-55

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

3/10/55

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cem.

24D. LOCATION (City, town, or county)

4360 Old Frederick Rd.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

3-7-55

REGISTRAR'S SIGNATURE

an Admick

25. FUNERAL DIRECTOR

John J. Bowman

ADDRESS

St. Hollins

THIS IS A PERMANENT RECORD.

PLEASE TYPE, OR WRITE WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.  
Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.  
THIS CERTIFICATE MUST BE FILED WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER DE



2439

Item 9, Film 100 4-27-55 et

02421

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 32

## I. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) LENGTH OF STAY (in this place)  
 TOWN Pikesville  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Park Heights Avenue

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Anne Arundel  
 CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Lothian  
 STREET ADDRESS (If rural, give location)

## 3. NAME OF DECEASED:

(First) (Middle) (Last)  
MARTHA ANN PETERS

4. DATE OF DEATH (Month) (Day) (Year)  
3 27 1955

## 5. SEX:

6. COLOR OR RACE:  
Female Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH:  
7-7-28

9. AGE last birthday: 26 1/2 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.  
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lothian, Md

12. CITIZEN OF WHAT COUNTRY? USA

## 13. FATHER'S NAME:

THOMAS PARKER

## 14. MOTHER'S MAIDEN NAME:

FLORENCE BEIL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  
No

16. SOCIAL SECURITY No.: none

## 17. INFORMANT &amp; ADDRESS:

John Parker Harwood, Md

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a)..... DUE TO Fracture dislocation of 4th cervical vertebra,

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)..... DUE TO Crushed chest, Comminuted fracture of pelvis, Comminuted fracture of right femur.

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

INTERVAL BETWEEN ONSET AND DEATH

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING CAUSE OF DEATH ☐

21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Street

21c. (City or town) (County) (State)  
Pikesville Baltimore Maryland

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 3/27/55 11:50AM

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR?  
Auto ran off road, struck utility pole.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

William Reese

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED  
 DEPUTY MEDICAL EXAMINER ☒  
 ASSISTANT MEDICAL EXAM. ☐

M. D. 3/28/55

23. BURIAL, CREMATION, REMOVAL (Specify):

BURIAL  
 DATE REC'D BY LOCAL REG. 3-29-55

DATE THEREOF

3-31-55

NAME OF CEMETERY OR CREMATORY

ADAM CHAPEL

LOCATION (City, town, or county)

BAYARD Md

(State)

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

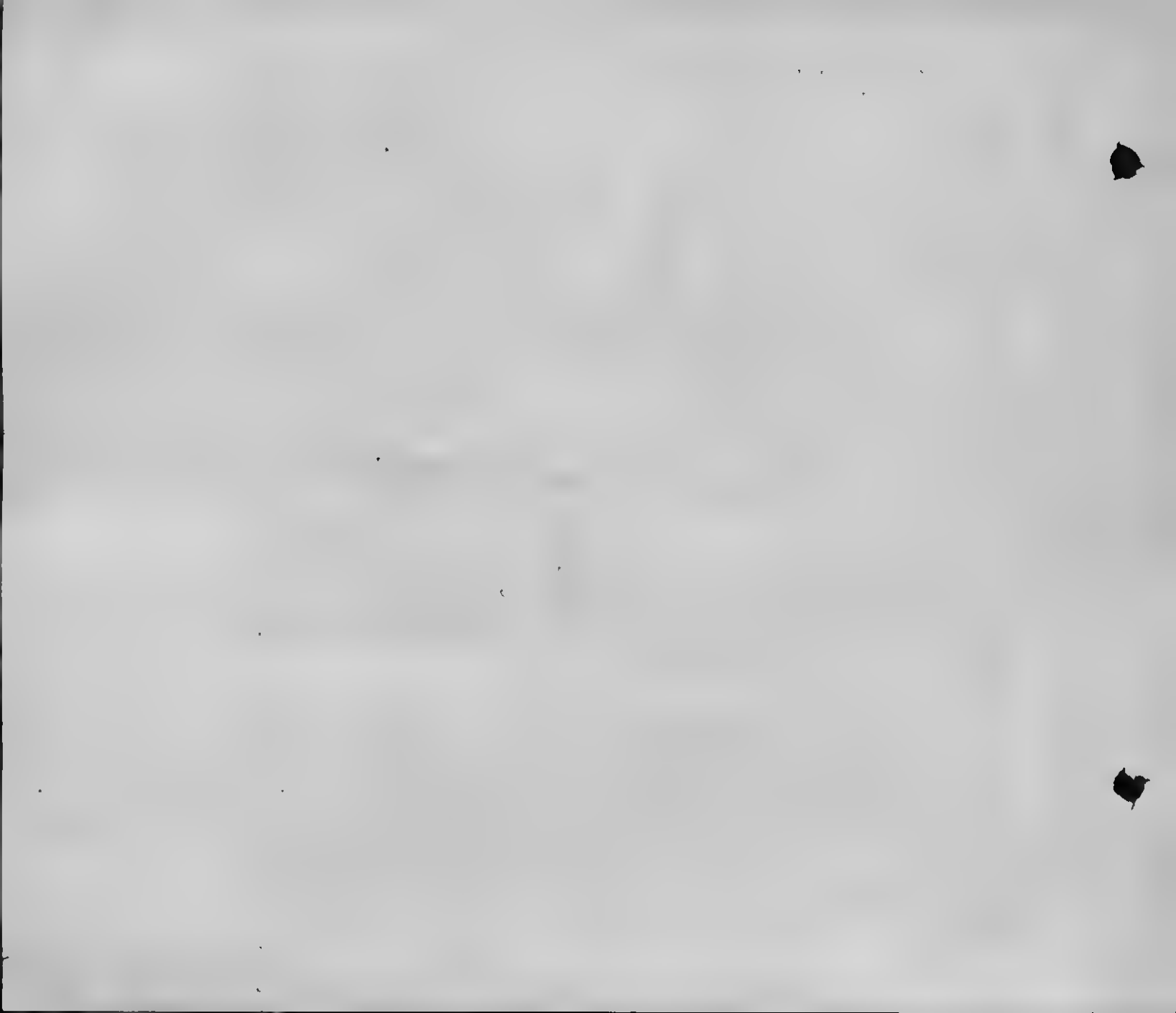
ADDRESS

William Reese 108 W. Washington

Annapolis, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK—Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

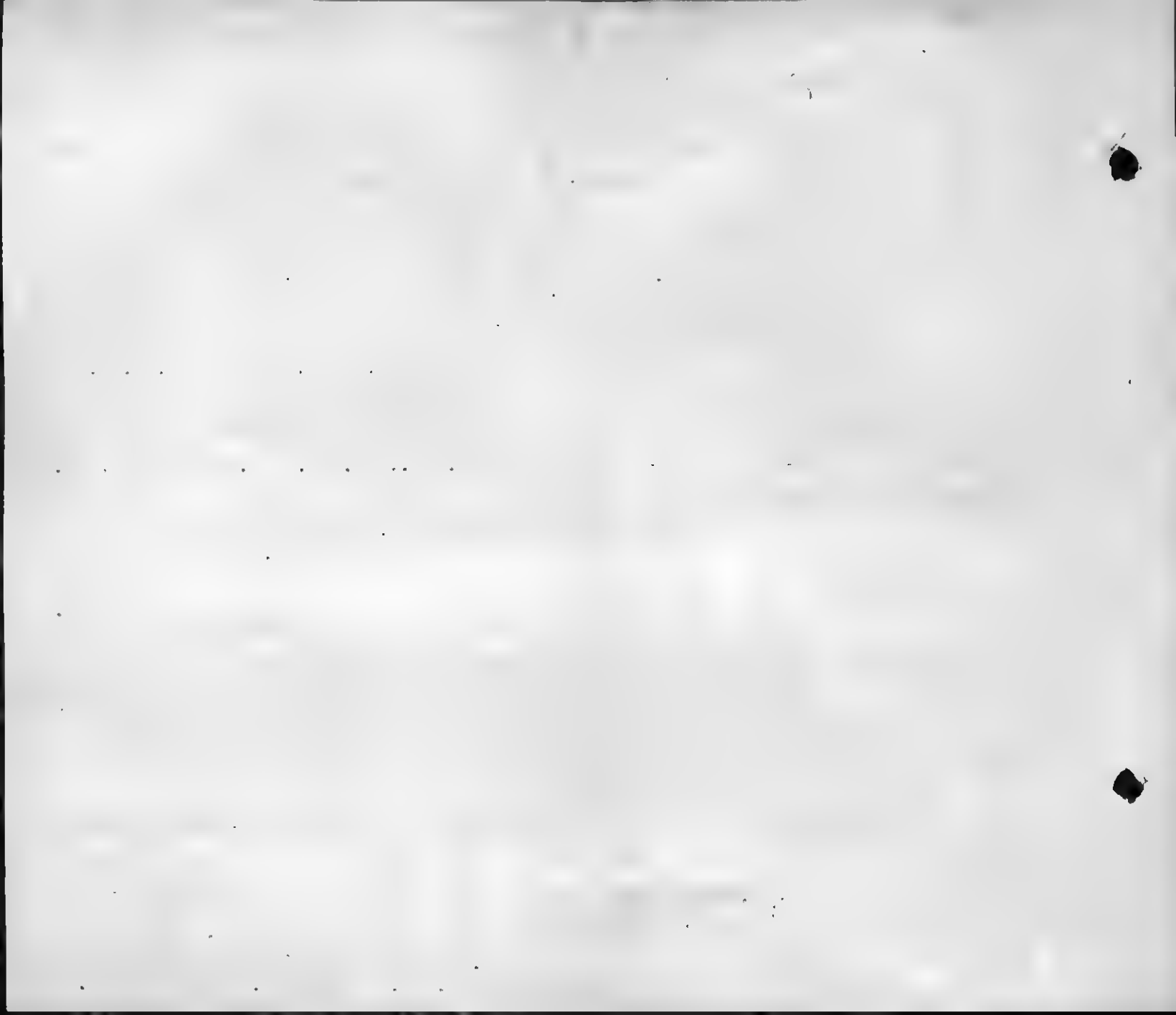
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02422

2440

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
X TOWN <u>Fort Howard</u>		<u>24 Hrs. 30 Min</u>		STREET ADDRESS (If rural give location) <u>3525 Hickory Avenue</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>							
3. NAME OF DECEASED. (First) <u>JOHN</u>		(Middle) <u>FRANK</u>		(Last) <u>PETTIS</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>March 6 1955</u>	
5. SEX. <u>Male</u>	6. COLOR OR RACE. <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>(separated) Married</u>	8. DATE OF BIRTH. <u>March 4, 1893</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Baker</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>William Pettis</u>				14. MOTHER'S MAIDEN NAME: <u>Annie MN: Dipper</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk): <u>Yes</u>		16. SOCIAL SECURITY No. <u>212-14-9270</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp. Fort Howard, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>162X</u>							
IMMEDIATE CAUSE							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				2 YEARS			
(A) BRONCHOGENIC CARCINOMA, RIGHT UPPER LOBE							
X X X X WITH METASTASES TO LEFT HUMERUS, LEFT							
X X X FEMUR AND LYMPH NODES							
X X X X PATHOLOGIC FRACTURE OF LEFT FEMUR				Approx. 36 HOURS			
Due To METASTASIS FROM BRONCHOGENIC CARCINOMA							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>ARTERIOSCLEROSIS, GENERALIZED</u>							
19A. DATE OF OPERATION. <u>3-5-55</u>				19B. MAJOR FINDINGS OF OPERATION			
				<u>Insertion of Kirschner wire into left tibia for traction purposes for pathologic fracture left femur</u>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> M.				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March 5, 1955</u> , to <u>March 6, 1955</u> , that he was the deceased and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Joseph M. Miller</u>				ADDRESS		DATE SIGNED	
<u>JOSEPH M. MILLER, M.D. Chief, Surgical Service, VAH, Fort Howard, Maryland</u>				<u>3-7-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3-9-55</u>		<u>Baltimore National</u>		<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3-8-55</u>		<u>A. W. Hedlund</u>		<u>Wm. Ticker &amp; Sons Funeral Home</u>		<u>Penna. Ave. &amp; North Ave., Baltimore, Md.</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

2441

02423

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Raspeburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Raspeburg</u>	
TOWN <u>Raspeburg</u>		TOWN <u>Raspeburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7939 Belair Rd.</u>		STREET ADDRESS (If rural, give location) <u>7939 Belair Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Alma</u>	(Middle) <u>B</u>	(Last) <u>Pielke</u>
4. DATE OF DEATH	(Month) <u>3</u>	(Day) <u>1</u>	(Year) <u>1955</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 24, 1894</u>
9. AGE last birthday <u>60</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (State or foreign country) <u>Germany</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	13. FATHER'S NAME <u>Ferdinand Blechstein</u>	14. MOTHER'S MAIDEN NAME <u>Gerald Pielke</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT AND ADDRESS <u>Mr. Gerald Pielke 7939 Belair Rd. Balt. Md.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <u>420.1 Myocardial infarction</u>			
Antecedent cause(s) <u>Chronic coronary failure</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>It is not this condition alone</u>			
II. OTHER SIGNIFICANT CONDITIONS <u>Report irregular change</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan.</u> , 19 <u>55</u> , to <u>Mar.</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>28th</u> , 19 <u>55</u> , and that death occurred at <u>6 AM</u> m., from the causes and on the date stated above.			
SIGNATURE: <u>John C. Hale</u>		ADDRESS: <u>7527 Edmonk Rd Balto Md</u>	
DATE SIGNED: <u>3-3-55</u>			
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>3/3/55</u>	<u>Parkwood</u>	<u>Balto. City Md.</u>
24. FUNERAL DIRECTOR	REGISTRAR'S SIGNATURE	ADDRESS	
<u>Mar 3-1955</u>	<u>John C. Hale</u>	<u>Funeral Home 7401 Belair Rd.</u>	

Dr. Hyde  
13 Clair Rd.

BUFFALO N. Y.

MAR 7



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The current age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
**2442** **CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

02424

Reg. Dist. No. **33-**

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Parkton</u> LENGTH OF STAY (to this place) <u>2 min.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - White Hall</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>York Rd.</u>		STREET ADDRESS (If rural, give location) <u>Wiseburg Rd.</u>	
3. NAME OF DECEASED (First) <u>Charles</u> (Middle) <u>A.</u> (Last) <u>Pisani</u>		4. DATE OF DEATH (Month) <u>MAR</u> (Day) <u>12</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>July 1, 1919</u>
9. AGE last birthday <u>35</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crane Operator</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	13. FATHER'S NAME <u>A. L. Pisani</u>	14. MOTHER'S MAIDEN NAME <u>Ruth A. Henry</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes.</u>	16. SOCIAL SECURITY No. <u>218-10-4350</u>	17. INFORMANT AND ADDRESS <u>A. L. Pisani - White Hall, Md.</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause <u>821X</u> (a) <u>MULTIPLE Compound fracture of the skull</u> Antecedent cause(s) <u>None</u> (b) <u>None</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>None</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.	PLACE (Home, farm, factory, street, or office bldg., etc.) INJURY <u>Route 111</u>	(CITY OR TOWN) <u>Parkton, Md.</u>	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>MAR 12 1955 11:20 am</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Thrown off motorcycle</u>	
22. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>Dr. M. France</u>		DATE SIGNED <u>3/13/55</u>	
23. BURIAL, CREMATION OR MOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>March 15 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Wiseburg Cemetery</u>		LOCATION (City, town, or county) (State) <u>White Hall, Balto. Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Charles E. Sullivan</u>		ADDRESS <u>1400 North Freedom, Pa.</u>	



2443

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

02425

Reg. Dist. No. 44

1. PLACE OF DEATH - COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MD.</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>SPARROWS PT.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS PT.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Beth. Steel Disp.</u>		STREET ADDRESS (If rural, give location) <u>704 "J" St.</u>	
3. NAME OF DECEASED (Type or Print) <u>ERNEST</u> (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>3-5-1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9-10-34</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>	11. BIRTHPLACE (State or foreign country) <u>Clarksville, Virginia</u>
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Mr. Lester Pleasant 302 Lister Ter. Md.</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

840X

Immediate cause

(a) ① Fractures - Compound - of Rt. Tibia & Fibula -  
Left Ft Femur - ② Fracture of pelvis, Rt. hip  
 (b) Lower ribs - ③ INTERNAL INJURIES -

Antecedent cause(s)

Diseases or conditions, if any,  
 giving rise to the above cause  
 stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY!

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office, hospital, etc.) OF INJURY <u>Street</u>	(CITY OR TOWN) <u>Hamm Point</u>	(COUNTY) <u>BALTO.</u>	(STATE) <u>MD.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3-5-55 10 a.m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <u>Crushed by Balto Trans Street Car</u>		

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, or thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

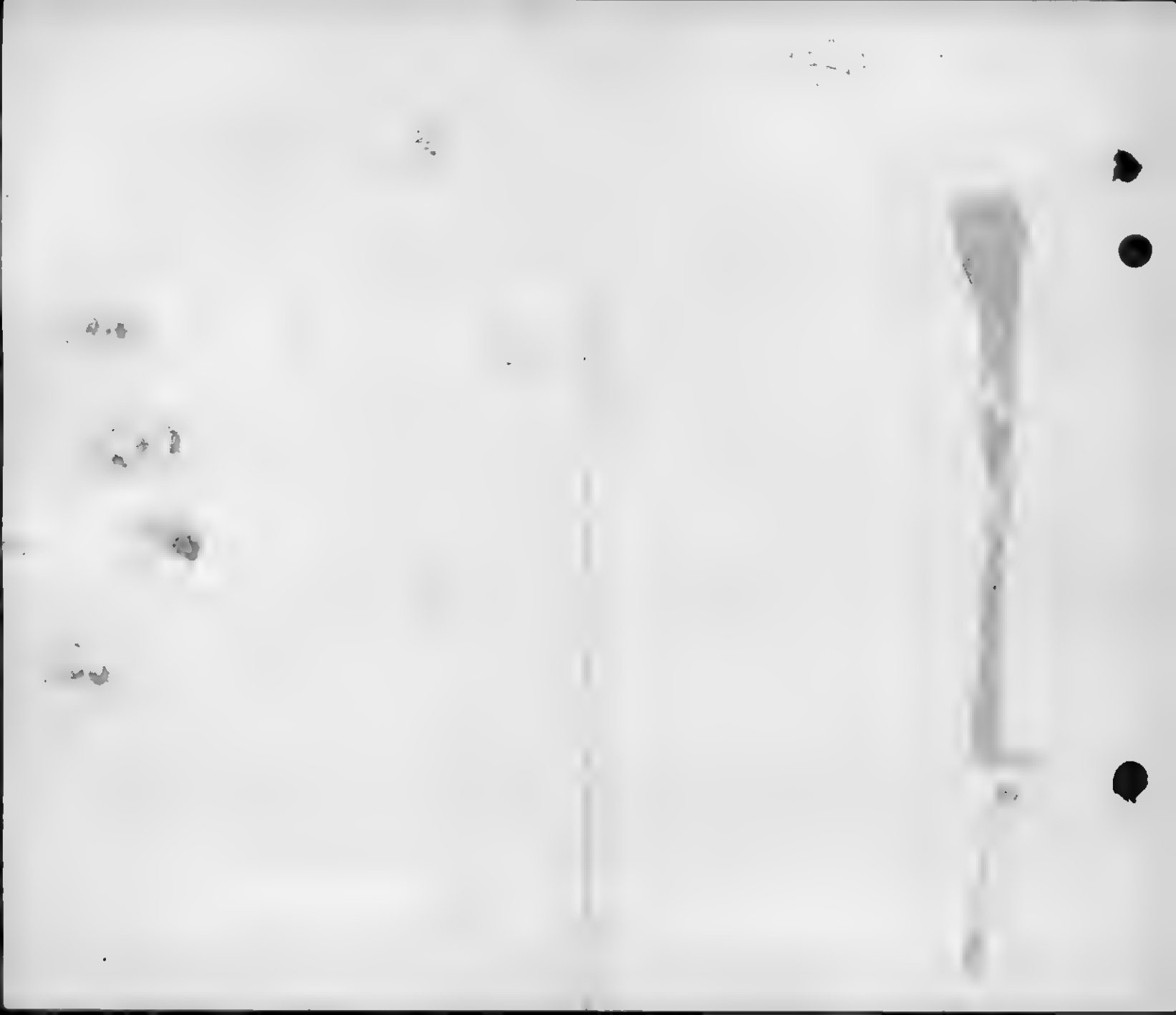
ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3-9-55</u>	NAME OF CEMETERY OR CREMATORY <u>Arbutus, Memorial Park</u>	LOCATION (City, town, or county) <u>Arbutus, Maryland</u>	(State)
DATE REC'D BY LOCAL REG. <u>3-7-55</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Charles R. Law</u>		ADDRESS <u>802 Madison Ave.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2446

02426

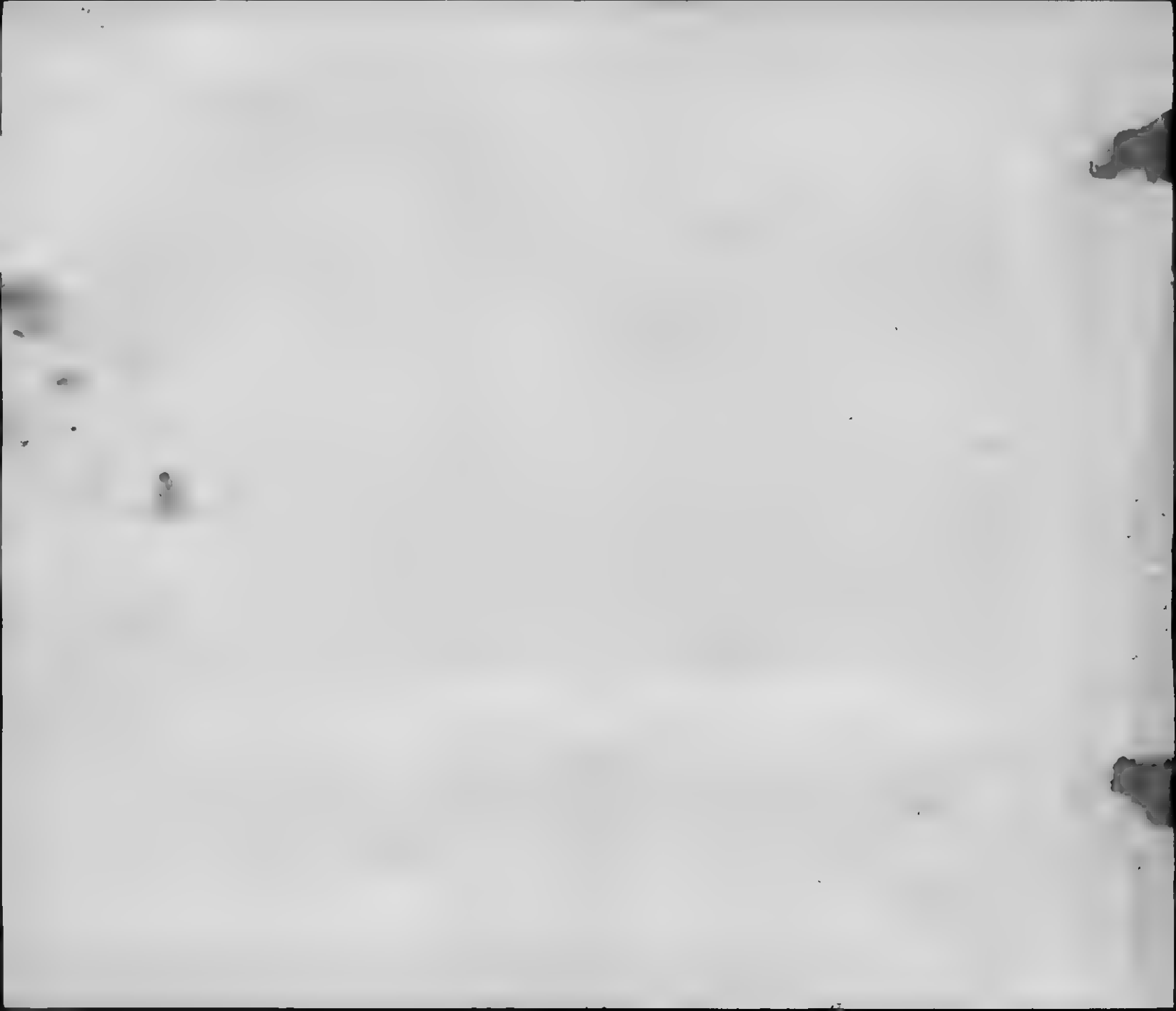
Reg. Dist. No. 45

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	BALTIMORE	STATE	MD. COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	ESSEX	CITY (If outside corporate limits write RURAL and give nearest town)	BALTIMORE 34-1-4
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Back River	STREET ADDRESS	3108 Woodring Av.
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First)	(Middle)	(Last)	(Month) (Day) (Year)
GEORGE		POLITES	3-12-55 10-
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
M	W.	MARRIED	64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Butcher	Grocery	Greece	✓
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Matthew		unk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
No-		212-34-4694	
17. INFORMANT & ADDRESS:		Son - Same	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				
475X Immediate cause (a)..... DROWNING DUE TO Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c).....				
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office, bldg., etc., INJURY)	21c. (City or town) (County) (State)		
		Balto.	Md.	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
3/12/55 M.		Apparently jumped in river		
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .				
SIGNATURE		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM.		
R. W. Fisher		DATE SIGNED 5-12-55		
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	3-15-55	Greek Cemetery	Windsor Mill Rd.	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
3/14/55	A. W. Hedrick	Lambros Inc. 440-E North Ave		



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2444

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

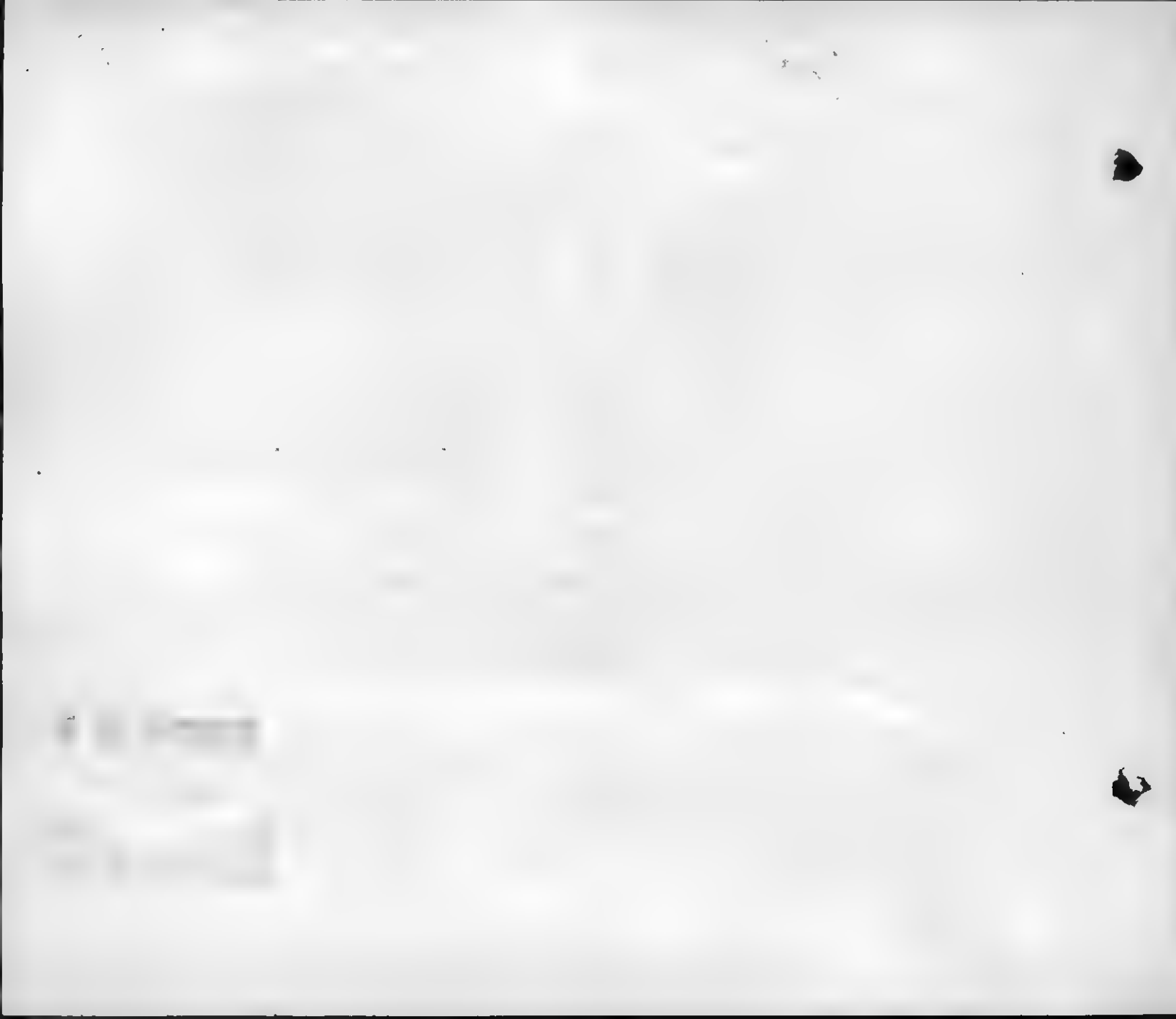
Item 12, Form 79 4-6-55 et

02427

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1 PLACE OF DEATH.				2 USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>TOWN Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hosp</u>				STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>TOWN Lutherville, Md.</u> STREET ADDRESS (If rural give location) <u>307 Lincoln Avenue</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Martha</u> <u>---</u> <u>RASCH</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>March 30</u> <u>1955</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify): <u>widow</u>		8. DATE OF BIRTH. <u>11-15-1876</u>	
9. AGE last birthday <u>78</u> yrs		10. AGE last birthday IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country): <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
13. FATHER'S NAME: <u>Beinsen</u>				14. MOTHER'S MAIDEN NAME: <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO.			
17. MEDICAL CERTIFICATION				17. INFORMANT'S ADDRESS <u>Mrs. Dorothea R. Stewart</u> <u>307 Lincoln Ave. Lutherville, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE <u>422.1</u>				(A) <u>Respiratory and cardiac failure</u>			
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST				(B) <u>Intracerebral hemorrhages</u> <u>7 wks</u>			
(C) <u>Arteriosclerotic cardiovascular disease</u> <u>years</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Para noid psychosis, senility</u> <u>2 years</u>			
19A. DATE OF OPERATION: <u>none</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/21</u> , <u>1955</u> , to <u>3/30</u> , <u>1955</u> that I last saw the deceased alive on <u>3/30</u> , <u>1955</u> , and that death occurred at <u>1:30 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>Lindsey P. Campbell</u>				ADDRESS <u>Spring Grove State Hosp</u>			
DATE SIGNED <u>3-30-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-2-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Decatur</u>		LOCATION (City, town, or county) <u>Alabama</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3/30/55</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>		24. FUNERAL DIRECTOR <u>F.C. Hignibotham</u>		ADDRESS <u>Ellicott City, Md</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

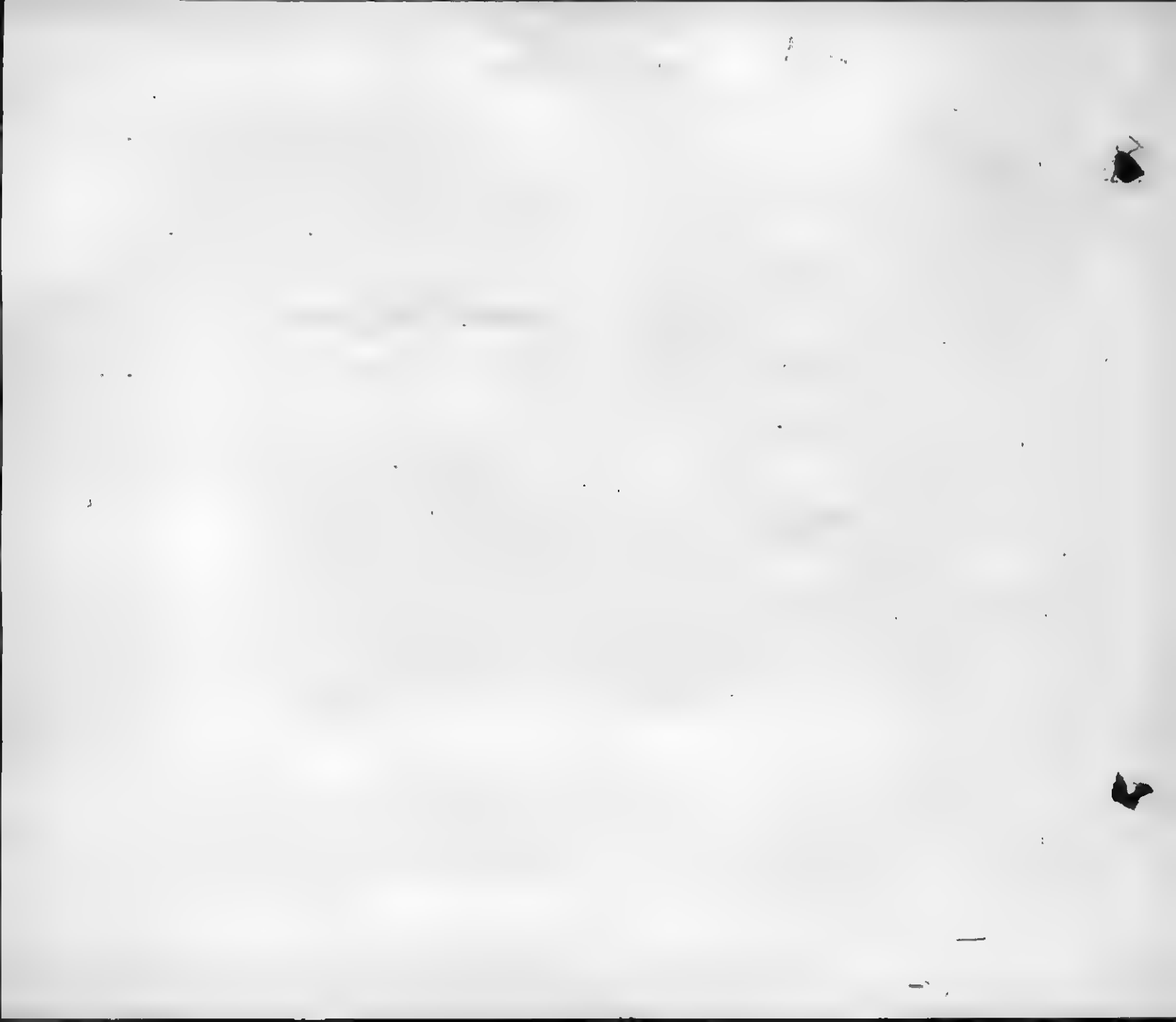
2445

## CERTIFICATE OF DEATH

02428

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Balto.</u> City	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hosp.</u>		STREET ADDRESS (If rural give location) <u>116 N. Pearl St.</u>	
3. NAME OF DECEASED (Type or Print)	First (Middle) (Last)	4. DATE (Month) (Day) (Year)	
<u>George</u>	<u>S</u> <u>Rausch</u>	<u>3</u> <u>22</u> <u>55</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, SEPARATED	8. DATE OF BIRTH: <u>May 9, 1897</u>
		9. AGE last birthday <u>57</u> yrs	10. MONTHS <u>5</u> DAYS <u>19</u> HRS <u>55</u> MIN.
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): <u>Laborer</u>	10B. KIND OF BUSINESS OR INDUSTRY: <u>unknown</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME: <u>George G. Rausch</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret Farrell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) <u>if Yes, give war or dates of service:</u>		16. SOCIAL SECURITY NO	
17. INFORMANT & ADDRESS: <u>George G. Rausch, 2605 E. Monument Street</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>163X Cancer of right lung</u>			<u>2 1/2 year</u>
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
(B) DUE TO			
(C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7/1/53</u> , to <u>3/22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/22/55</u> , 19 <u>55</u> , and that death occurred at <u>8.A</u> M. from the causes and on the date stated above.			
SIGNATURE <u>S. Wachler</u>		DATE SIGNED <u>3/24/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Old St. Pauls</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-23-55</u>		REGISTRAR'S SIGNATURE <u>D. W. Healy</u>	
		24. FUNERAL DIRECTOR <u>Wm Cook Inc.</u>	
		ADDRESS <u>1217 St. Paul St.</u>	



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

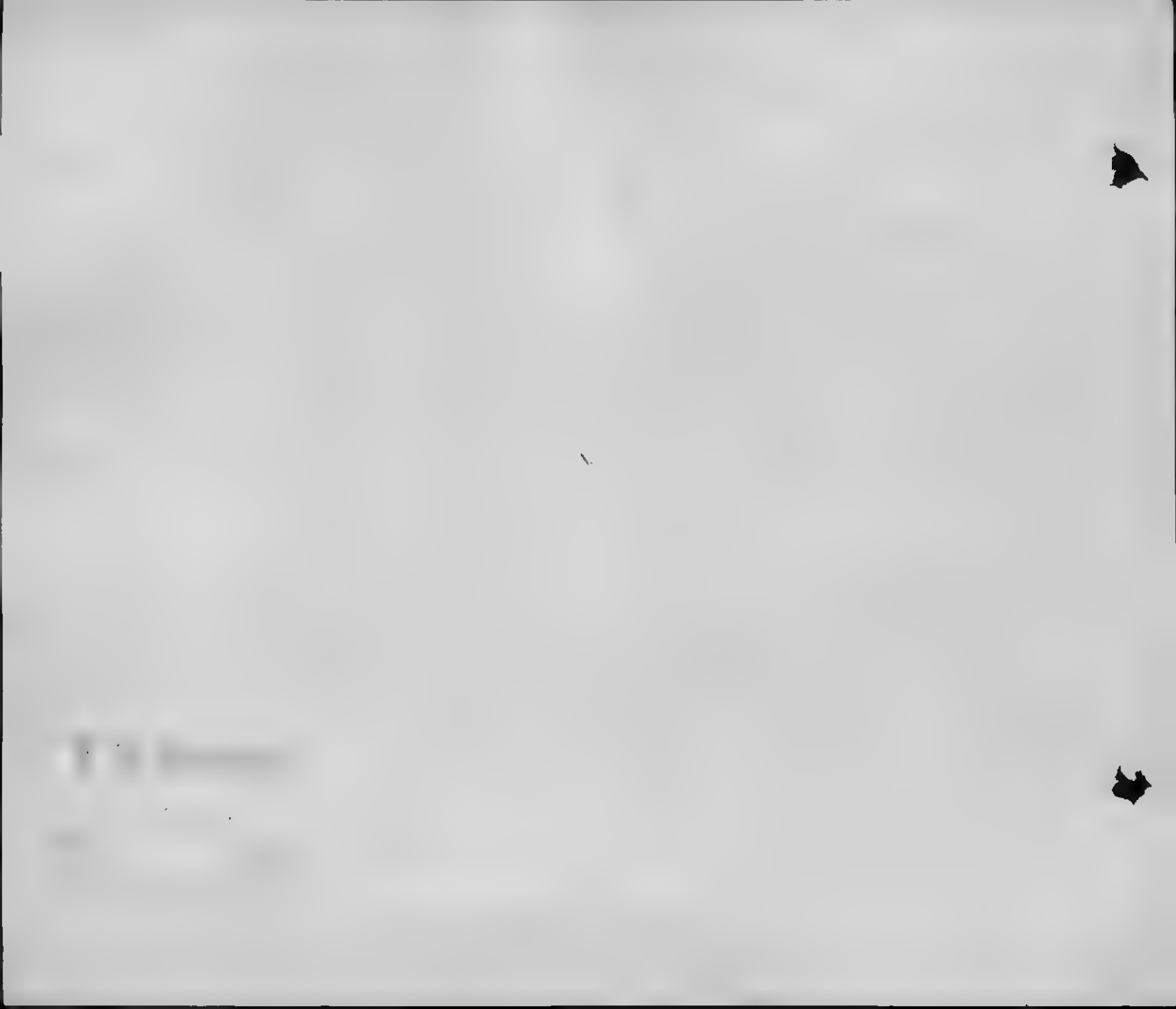
2447				02429			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				Reg. Dist.			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 30							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Harford	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Catonsville		LENGTH OF STAY (in this place) 2 Mon. 13 day		CITY (If outside corporate limits write RURAL and give nearest town) TOWN Havre de Grace		10-24	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital				STREET ADDRESS (If rural, give location) Havre de Grace, Maryland			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) Frank		(Middle)		(Last) Reginaldi		(Month) 3 (Day) 18 (Year) 19 55	
5. SEX: M		6. COLOR OR RACE: W		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married		8. DATE OF BIRTH: 11-25-1888	
9. AGE last birthday: 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): fireman		11. BIRTHPLACE (State or foreign country): Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Joseph Reginaldi				14. MOTHER'S MAIDEN NAME: Teresa ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or date of service) no				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Hospital records	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
903.7 Immediate cause (a)..... <u>pending Sub dural hemorrhage</u> DUE TO Antecedent cause(s) (b)..... <u>Cerebral compression</u> Diseases or conditions, if any, giving rise to the above cause DUE TO <u>Uremia Chronic Nephritis</u> stating underlying cause last (c)..... <u>Accident head injury</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office, bldg., etc.) OF INJURY Hospital		21c. (City or town) Catonsville		(County) Baltimore (State) Maryland	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 3- 14 55 8:45 M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? fell coming out of shower causing small laceration on top of head			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Leo M. Kueffer</u>		1010 Leek an		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED 3-18-55	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>burial</u>		DATE THEREOF 3/22/55		NAME OF CEMETERY OR CREMATORY <u>Mt. Erie</u>		LOCATION (City, town, or county) <u>Havre de Grace Md</u> (State)	
DATE REC'D BY LOCAL REG. 3-21-55		REGISTRAR'S SIGNATURE <u>A W Hedrick</u>		24. FUNERAL DIRECTOR <u>Burroughs &amp; Son</u>		ADDRESS <u>Havre de Grace Md</u>	





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2448				02430			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 35							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Balto.</i>		MARYLAND		STATE <i>Ind.</i>		COUNTY <i>Balto.</i>	
X CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)		X	
TOWN <i>White Hall, Ind.</i>		<i>2 yrs.</i>		TOWN <i>White Hall, Ind.</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Bray Stone Rd.</i>				STREET ADDRESS (If rural, give location) <i>Bray Stone Rd.</i>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <i>JOSEPH</i>		(Middle) <i>ESTIL</i>		(Last) <i>REPASS</i>		(Month) <i>Mar</i> (Day) <i>26</i> (Year) <i>1955</i>	
5. SEX: <i>Male</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Single</i>		8. DATE OF BIRTH: <i>Aug 6, 1911</i>	
9. AGE last birthday: <i>43</i> yrs		10. BIRTHPLACE (State or foreign country): <i>Tazewell, Va.</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Agriculture</i>		11. BIRTHPLACE (State or foreign country): <i>Tazewell, Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Bailey Repass.</i>				14. MOTHER'S MAIDEN NAME: <i>Maggie Harding</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No.</i>		16. SOCIAL SECURITY No.: <i>223-12-6544</i>		17. INFORMANT & ADDRESS: <i>Ely. Watkins (sister) White Hall, Md.</i>			
(If Yes, give war or dates of service) <i>No.</i>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
420.1 Immediate cause (a) <i>Coronary artery Disease</i>							
DUE TO							
Antecedent cause(s) (b) <i>None.</i>							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>None.</i>							
19a. DATE OF OPERATION: <i>None.</i>				19b. MAJOR FINDING OF OPERATION: <i>None.</i>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>None.</i>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <i>None.</i>		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>None.</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i>None.</i>		21f. HOW DID INJURY OCCUR? <i>None.</i>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <i>D. D. Cooper</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>Mar 26 '55</i>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF: <i>March 29, 1955</i>		NAME OF CEMETERY OR CREMATORY: <i>Wiseburg Cemetery</i>		LOCATION (City, town, or county) (State): <i>White Hall, Balto. Co., Md.</i>	
DATE REC'D BY LOCAL REG: <i>3/29/56</i>		REGISTRAR'S SIGNATURE: <i>J. F. Fiddon</i>		24. FUNERAL DIRECTOR: <i>Jacob Hartenstein</i>		ADDRESS: <i>New Freedom, Pa.</i>	



2449

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>MD</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville Md.</u>	LENGTH OF STAY (in this place) <u>9 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	<u>3401-4</u>
X TOWN <u>Cockeysville Md.</u>		STREET ADDRESS (If rural give location) <u>1304 W. Lexington St</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Md. Masonic Home</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<u>Mary W. Ridgaway</u>		<u>Mar. 7 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>None</u>	8. DATE OF BIRTH: <u>Aug. 9 - 1864</u>
9. AGE last birthday: <u>90</u> yrs. <u>7</u> Months <u>7</u> Days		10. IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Taken care of home, own home</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Talbot Co. Md</u>	
11. BIRTHPLACE (State or foreign country): <u>Talbot Co. Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>William Wilson Todd</u>		14. MOTHER'S MAIDEN NAME: <u>Honora Gregory</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT'S ADDRESS: <u>Laura M. Schroeder, Cockeysville</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
422.1 IMMEDIATE CAUSE (A) <u>Arterio sclerosis</u>			
ANTECEDENT CAUSE (B) <u>Coronary Vascular Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Disease</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10/23, 1946</u> to <u>Mar. 7, 1955</u> that I last saw the deceased alive on <u>Mar 7, 1955</u> and that death occurred at <u>4:25 PM</u> , from the causes and on the date stated above			
SIGNATURE <u>Frank T. Kees</u>		ADDRESS <u>Cockeysville Md</u> DATE SIGNED <u>3/7/55</u>	
M. D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR ADDRESS	
DATE REC'D BY LOCAL REGISTRAR <u>3/7/55</u>		REGISTRAR'S SIGNATURE <u>T. M. Schroeder</u>	
DATE THEREOF <u>3/10/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>	
		LOCATION (City, town, or county) <u>Baltimore</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

18 11 1955

RECEIVED

2450

## CERTIFICATE OF DEATH

Reg. Dist. No.

300

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MD.</u> COUNTY <u>BALTO.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
52 TOWN <u>CATONSVILLE</u>		4 MO.		TOWN <u>CATONSVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 6 CEDARWOOD RD.				6 CEDARWOOD RD.			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH			
MABEL M. RIGGS				MAR. 20 1955			
5. SEX: F.		6. COLOR OR RACE: W.		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOW		8. DATE OF BIRTH: JULY 17, 1873	
				9. AGE (last birthday) 81 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H.W.				10B. KIND OF BUSINESS OR INDUSTRY: C.H.		11. BIRTHPLACE (State or foreign country): PA.	
13. FATHER'S NAME: CHARLES R. SIMPSON				14. MOTHER'S MAIDEN NAME: ELEANOR PHILE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				17. INFORMANT & ADDRESS: MR. CHARLES H. RIGGS, 6 CEDARWOOD			
18. SOCIAL SECURITY NO.							
15. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE				11 da.			
ANTECEDENT CAUSE (S)				10 yr.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) Cerebral Hemorrhage							
DUE TO							
(B) Coronary Arteriosclerosis							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19B. MAJOR FINDINGS OF OPERATION							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12-18, 1954 to 3-20, 1955, that I last saw the deceased alive on 3-20, 1955, and that death occurred at 3:15 P.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
MABEL M. RIGGS				3-22-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY			
BURIAL				FERNWOOD CEMETERY			
DATE REC'D BY LOCAL REGISTRAR				LOCATION (City, town, or county) (State)			
3-23-55				PHILADELPHIA PA.			
REGISTRAR'S SIGNATURE				24. FUNERAL DIRECTOR			
R.W. Nodine				ADDRESS			
				HARRY H. WITZKE 4101 EDMONDSON AVE.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2451

## MARYLAND STATE DEPARTMENT OF HEALTH

02433

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>BALTO CO</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>39 WADE AVE</u>		STREET ADDRESS (If rural, give location) <u>39 WADE AVE.</u>	
3. NAME OF DECEASED (Type or Print) <u>JAMES</u> (First) <u>ITRWIN</u> (Middle) <u>RIORDAN</u> (Last)		4. DATE OF DEATH Month <u>3</u> Day <u>15</u> Year <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>1/8/1904</u>
9. AGE last birthday <u>51</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>MD</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLUMBERS HELPER</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DENNIS J. RIORDAN</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE CULLEN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>JOSEPH RIORDAN</u>	

## 15. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Coronary thrombosis

INTERVAL BETWEEN ONSET AND DEATH

11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.PLACE (Home, farm, factory, street, office bldg., etc.)  
OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

3-18-55V.E. BarryMACNABB & SON

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





02434

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

File GL79 3-21-55

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE MD</u>	
TOWN <u>90</u>		TOWN <u>31-14</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ridgeway Manor Nursing Home</u>		STREET ADDRESS (If rural give location) <u>1041 Pine Sts Ave</u>	
3. NAME OF DECEASED (First) <u>ROSIE</u> (Middle) <u>RUEHL</u> (Last)		4. DATE OF DEATH (Month) <u>MARCH</u> (Day) <u>9</u> (Year) <u>1955</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Sept 30, 1867</u>
9. AGE last birthday <u>87</u> yrs.		10. AGE last birthday (If under 1 year) (If under 24 hrs.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT <u>Milton Ruehl 3501 Coolidge Ave</u>			

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>CORONARY Occlusion</u>		<u>10 hours</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>GEN. A.S.</u>		<u>20 yrs (?)</u>
(c) <u>A.S.C.U.D.</u>		<u>20 yrs (?)</u>

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/25, 1955, to 3/9, 1955, that I last saw the deceased alive on 3/8, 1955, and that death occurred at 5 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR OTHER	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>3-11-55</u>	<u>London Park Cem</u>	<u>BALTO MD</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3-10-55</u>	<u>R. W. Federal</u>	<u>Pratt &amp; Stricker &amp; S.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2453

## CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY	
CITY (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		LENGTH OF STAY (in this place) <u>8 mos. 3 wks</u>		CITY (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hosp</u>				STREET ADDRESS (if rural give location) <u>4502 Kathland Ave.</u>			
3. NAME OF DECEASED: (Type or Print) <u>Nellie</u> (First) <u>Segrue</u> (Middle) <u>Ryan</u> (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>3 - 7</u> <u>1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED, DIVORCED, (Specify): <u>W</u>	8. DATE OF BIRTH: <u>Nov. 14</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Milliner</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>James Segrue</u>				14. MOTHER'S MAIDEN NAME: <u>Bridget</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Hospital records</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebrovascular thrombosis</u>				1 day			
ANTECEDENT CAUSE (B) <u>Cerebral arteriosclerosis</u>				unk.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Generalized arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-18</u> , 1954, to <u>3-7</u> , 1955, that I last saw the deceased alive on <u>3-7</u> , 1955, and that death occurred at <u>11:45 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Marie Frances Woodward</u>				ADDRESS <u>M.D. Spring Grove State Hosp.</u>		DATE SIGNED <u>3-7-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar 10/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Not known</u>		LOCATION (City, town, or county) (State) <u>Washington DC</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-8-55</u>		REGISTRAR'S SIGNATURE <u>G.W. Hedden</u>		24. FUNERAL DIRECTOR <u>Harry M. Minaros</u>		ADDRESS <u>4204 Ridgewood Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

02436

2451

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Raspeburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Raspeburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>#397, King Avenue</u>		STREET ADDRESS (If rural, give location) <u>#397, King Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>CATHERINE SAHLMAN</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>10th</u> (Year) <u>1955</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 17, 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	9. AGE last birthday <u>66</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Balto. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Christ</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Stevens</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mr. J. M. Sahlman, 397 King Ave. Balto. 6, Md.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4-20-1  
Immediate cause(a) Coronary Occlusion disease  
(b) Arteriosclerotic Cardio-Vascular  
(c)INTERVAL BETWEEN ONSET AND DEATH  
Sudden  
1 yr.Antecedent cause(s)  
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause lastII. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb 1, 1955, to March 10 1955, that I last saw the deceasedalive on March 10, 1955; and that death occurred at 4 P. m., from the causes and on the date stated above.SIGNATURE [Signature] (Degree or title) ADDRESS Balto 6 Md DATE SIGNED 3/11/55

23. BURIAL, CREMATION REMOVAL (Specify) <u>burial</u>		DATE THEREOF <u>Mar. 11, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Raspeburg Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

$$f = \max_{x \in X} g(x, v) = v^*$$

## MARYLAND STATE DEPARTMENT OF HEALTH

02437

2411 N. Charles Street, Baltimore

2322

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>13</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>51</u> TOWN <u>Landsdowne</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>51</u> TOWN <u>Landsdowne</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>137 Clyde Avenue</u>		STREET ADDRESS (If rural give location) <u>137 Clyde Avenue</u>	
3. NAME OF DECEASED (Type or Print) <u>Naula</u> (First) <u>Saral</u> (Middle) (Last)		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>5</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1871</u>
9. AGE last birthday <u>84</u> yrs.		10. If under 1 year: Months <u>3</u> Days <u>5</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT Country? <u>USA</u>	
13. FATHER'S NAME <u>Israel Israelson</u>		14. MOTHER'S MAIDEN NAME <u>Freda</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>Baltimore</u>	
17. INFORMANT <u>Mrs. Nellie Jeffers - 2815 Hilldale Ave</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>about 6 mos.</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>151X Carcinoma of Stomach</u>		
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>about Oct. 1954</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Stomach</u>		

21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from about 1940 to 3-8, 1955, that I last saw the deceased alive on 3-8, 1955, and that death occurred at 4:15 p.m., from the causes and on the date stated above.

SIGNATURE R. Highstein M.D. ADDRESS 888 W. Lombard St DATE SIGNED 3-9-55

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Mar 9/55</u>	NAME OF CEMETERY OR CREMATORY <u>Anshe Amunah</u>	LOCATION (City, town, or county) <u>Baltimore, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>3-9-55</u>	REGISTRAR'S SIGNATURE <u>W. H. ...</u>	24. FUNERAL DIRECTOR <u>one</u>	ADDRESS <u>Sal. ... - 1124-26 W. North Avenue</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

02438

2323

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balt.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Arbutus</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Arbutus</u> 51	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4301 Alan Drive</u>		STREET ADDRESS (If rural, give location) <u>4301 Alan Drive</u>	
3. NAME OF DECEASED (Type or Print) <u>George W. Schaefer</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>13</u> (Year) <u>1953</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>11/2/1881</u>
9. AGE last birthday <u>73</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Martin Schaefer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wicklein</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Mrs Anna M. Schaefer 4301 Alan Drive</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4. Immediate cause (a) Chronic Myocarditis and myocardial degeneration

Antecedent cause(s) (b) none

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) none

INTERVAL BETWEEN ONSET AND DEATH

2 yearsII. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June 8, 1953, to March 13, 1955, that I last saw the deceased alive on March 8, 1955, and that death occurred at 11:45 A.M., from the causes and on the date stated above.

SIGNATURE: Melvin N. Borden (Degree or title) M.D. ADDRESS 5000 Old Frederick Road Balt 29 DATE SIGNED 3/14/55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Buried</u>	<u>3/16/55</u>	<u>Oak Lawn Cem.</u>	<u>7225 Eastern Ave.</u>	<u>Baltimore</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3/14/55</u>	<u>John G. Brown</u>	<u>John G. Brown</u>	<u>2401 St. Johns St.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2455

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Parkville LENGTH OF STAY (in this place)  
 TOWN Parkville

HOSPITAL OR INSTITUTION OR STREET ADDRESS 1604 Orlando Road

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Baltimore  
 CITY (If outside corporate limits, write RURAL and give nearest town) Parkville  
 TOWN Parkville

STREET ADDRESS (If rural give location) 1604 Orlando Avenue #14

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

Mrs. Ella R. Scherschel

4. DATE (Month)

(Day)

(Year)

OF DEATH: March 22nd 1955

## 5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH:

9. AGE last birthday

IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

female white  
 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country) Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

## 13. FATHER'S NAME:

? Lezers

## 14. MOTHER'S MAIDEN NAME:

? Hyde Maryland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

15. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS:

Mr. John H. Neal Hyde Maryland

## 16. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1  
 IMMEDIATE CAUSE

(A)

DUE TO

ANTECEDENT CAUSE (S)

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(C)

Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

Sudden (only)  
(seconds)

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION:

None

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

M.

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 1954, to 22 March 1955, that I last saw the deceased alive on Jan 15, 1955, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial  
 DATE REC'D BY LOCAL REGISTRAR 8-23-55

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck, 5305 Harford Road #14

MARGIN RESERVED FOR BINDING

VS. A11-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Molz  
7425 Harford Road

Please Call HA 6 1460 when ready.

M.R.G.

## MARYLAND STATE DEPARTMENT OF HEALTH

02440

2411 N. Charles Street, Baltimore

2456

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Fullerton md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Joppa Rd</u>		STREET ADDRESS (If rural, give location) <u>Joppa Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Caroline S Schwartz</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>27</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Jan 11-1876</u>
9. AGE last birthday <u>79 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Co md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Dietz</u>	
14. MOTHER'S MAIDEN NAME <u>Katherine Pilfber</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT AND ADDRESS <u>Mrs W Schwartz Joppa Rd</u>	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4201  
Immediate cause

(a) .....

Cerebral anoxia

INTERVAL BETWEEN ONSET AND DEATH

6 hrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) .....

Congestive heart failure4 hrs

(c) .....

Myocardial infarction6 hrs

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 1, 1955, to March 27, 1955, that I last saw the deceasedalive on March 26, 1955, and that death occurred at 1:15 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS



2457

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

## 1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

X TOWN Owings Mills

(in this place)

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS12 Rosewood State Tr. School

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MarylandCOUNTY Harford

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN Aberdeen

12-31-2

STREET  
ADDRESS

(If rural give location)

207 Ryland Drive

3. NAME OF  
DECEASED:

(First)

Albert

(Middle)

Ray

(Last)

Scott, Jr.4. DATE  
OF  
DEATH:

(Month)

3

(Day)

8

(Year)

19 55

## 5. SEX:

male6. COLOR OR  
RACE:W7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify): single

## 8. DATE OF BIRTH:

12/11/46

## 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

8 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION. Give kind of  
work done during most of working life,  
even if retired):10b. KIND OF BUSINESS OR  
INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

Pennsylvania12. CITIZEN OF WHAT  
COUNTRY?U.S.A.

## 13. FATHER'S NAME:

Albert Ray Scott, Sr.

## 14. MOTHER'S MAIDEN NAME:

Geraldine Simen15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)

## 16. SOCIAL SECURITY NO.:

## 17. INFORMANT &amp; ADDRESS:

Rosewood Records, Owings Mills, Md.

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

570.0

Immediate cause

(a) Paralytic Ileus and Peritonitis  
DUE TO

Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last.(b) Intussusception of Ileum  
DUE TO

(c)

Interval Between  
Onset And Deatha few daysa few days

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing deathCongenital malformation of brain

since birth

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☒ No ☐21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURY m.INJURY OCCURRED  
While at Not While  
Work ☐ At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/17, 19 52, to 3/8, 19 55, that I last saw the deceased  
alive on 3/8, 19 55, and that death occurred at 11:20 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION,  
REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL  
REGISTRAR

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

Sigla B. Johns M.D. Rosewood St. School Owings Mills, Md.  
Barney 3-12-55 St. LORETTA All eghany Co Pa  
3-9-55 Mary B. Elime J. S. Elime and Sons Reisterstown  
Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 16 1955

RECEIVED



2458

## CERTIFICATE OF DEATH

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X TOWN WOODLAWN MD</u>		LENGTH OF STAY (in this place) <u>4</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u>		<u>3111 4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>12 AUGSBURG HOME</u>				STREET ADDRESS (If rural give location) <u>6067 CAMPFIELD RD</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>ANNA</u>		(Middle) <u>MARG.</u>		(Last) <u>SEIFRIED</u>	
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>WIDOW</u>		8. DATE OF BIRTH: <u>Oct. 10, 1883</u>	
4. DATE OF DEATH:		(Month) <u>MARCH</u>		(Day) <u>29</u>		(Year) <u>1955</u>	
9. AGE last birthday: <u>71</u> yrs.		If UNDER 1 YEAR		If UNDER 24 HRS		Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>NONE</u>		11. BIRTHPLACE (State or foreign country): <u>BALTO. MD.</u>	
13. FATHER'S NAME: <u>JOSEPH WESTERKAM.</u>				14. MOTHER'S MAIDEN NAME: <u>FREDERICA VOGEL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>-</u>		17. INFORMANT & ADDRESS <u>RECORDS AUGSBURG HOME</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause (a) <u>Virus Pneumonia</u>						<u>6 wks.</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Cerebral Hemorrhage</u>						<u>5 days</u>	
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Incurable bolitis</u>							
19a. DATE OF OPERATION: <u>None</u>				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 15</u> , 19 <u>50</u> , to <u>March 29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>March 24</u> , 19 <u>55</u> , and that death occurred at <u>4108 Liberty Hts</u> , from the causes and on the date stated above.							
SIGNATURE <u>Paul L. Chamberlain M.D.</u>		(Degree or title)		ADDRESS <u>Baltimore 7-Md-3-59-51</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>4/1/55</u>		NAME OF CEMETERY OR CREMATORY <u>BALTO. Cem.</u>		LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-30-55</u>		REGISTRAR'S SIGNATURE <u>E. W. Hedrick</u>		24. FUNERAL DIRECTOR <u>Paul Hermann</u>		ADDRESS <u>6067 Hayford Rd</u>	



2459

## CERTIFICATE OF DEATH

Reg. Dist. No.....

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Randelstown LENGTH OF STAY (in this place)  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 8306 Liberty Rd.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Baltimore  
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Randelstown  
 STREET ADDRESS (If rural, give location) 8306 Liberty Rd.,

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

Mary E. Shupp

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

Mar. 8, 1955

## 5. SEX:

female

## 6. COLOR OR RACE:

white

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Married

## 8. DATE OF BIRTH:

1900

## 9. AGE last birthday:

54

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days

Hours Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

## 10b. KIND OF BUSINESS OR INDUSTRY:

home

## 11. BIRTHPLACE (State or foreign country):

Maryland

## 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

Otho J. Shank

## 14. MOTHER'S MAIDEN NAME:

Cline

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

?

## 17. INFORMANT &amp; ADDRESS:

Mr. Bast Boonsboro, Md.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

260X  
Immediate cause(a).....  
DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b).....  
DUE TO

(c).....

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION:

## INTERVAL BETWEEN ONSET AND DEATH

when

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While nt work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

## 20. AUTOPSY?

Yes ☐ No ☐

22. I hereby certify that I attended the deceased from.....3-6-55....., 1955, to.....3-8-55....., 1955, that I last saw the deceased alive on.....3-8-55....., 1955, and that death occurred at.....6:35.....am., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

3-12-55BoonsboroBoonsboro, Md.Boonsboro, Md.Bast Funeral Home Boonsboro, Md.

MARGIN RESERVED FOR BINDING

5 7 0 8 10

0 1 0

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

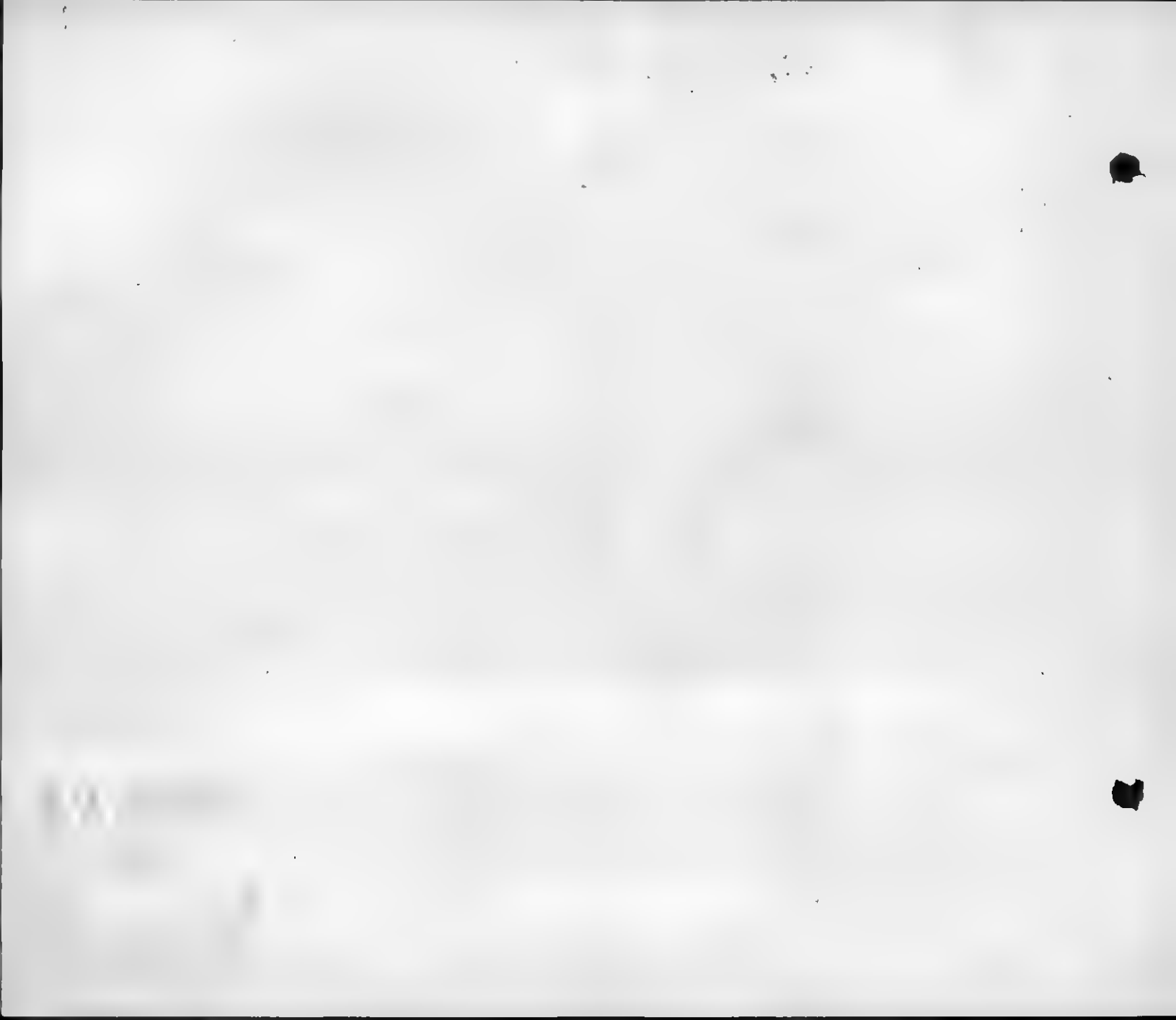
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 102444

2460

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Ann Arundel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Riva</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>		LENGTH OF STAY (in this place) <u>11mo. 11days</u>		STREET ADDRESS (If rural give location) <u>14 Spring Grove State Hospital</u>			
3. NAME OF DECEASED (Type or Print) <u>James Smallwood</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>March 31, 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>July 19th, 1881</u>	
9. AGE last birthday <u>73</u> yrs		10. MONTH <u>March</u> Days <u>31</u> Hours <u>19</u> Min. <u>55</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10A. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Carpenter</u>				10B. KIND OF BUSINESS OR INDUSTRY:			
13. FATHER'S NAME: <u>Rubin Smallwood</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Unknown</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE <u>450.0</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
(A) <u>Congestive heart failure</u>							
(B) <u>Generalized arteriosclerosis</u>				<u>Years</u>			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic brain syndrome assoc. w/ senile brain</u>				<u>Years</u>			
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-20-</u> , 19 <u>54</u> to <u>3-31-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/31</u> , 19 <u>54</u> , and that death occurred at <u>3:25 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>S. Wachler</u>		DATE SIGNED <u>3-31-55</u>		ADDRESS <u>Spring Grove State Hospital</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 2, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		LOCATION (City and county) <u>Baltimore, Md.</u> (State) <u>Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-2-55</u>		REGISTRAR'S SIGNATURE <u>V.E. Harris</u>		24. FUNERAL DIRECTOR <u>F. B. Wippert</u>		ADDRESS <u>1300 Rutaw Pl</u>	



2461

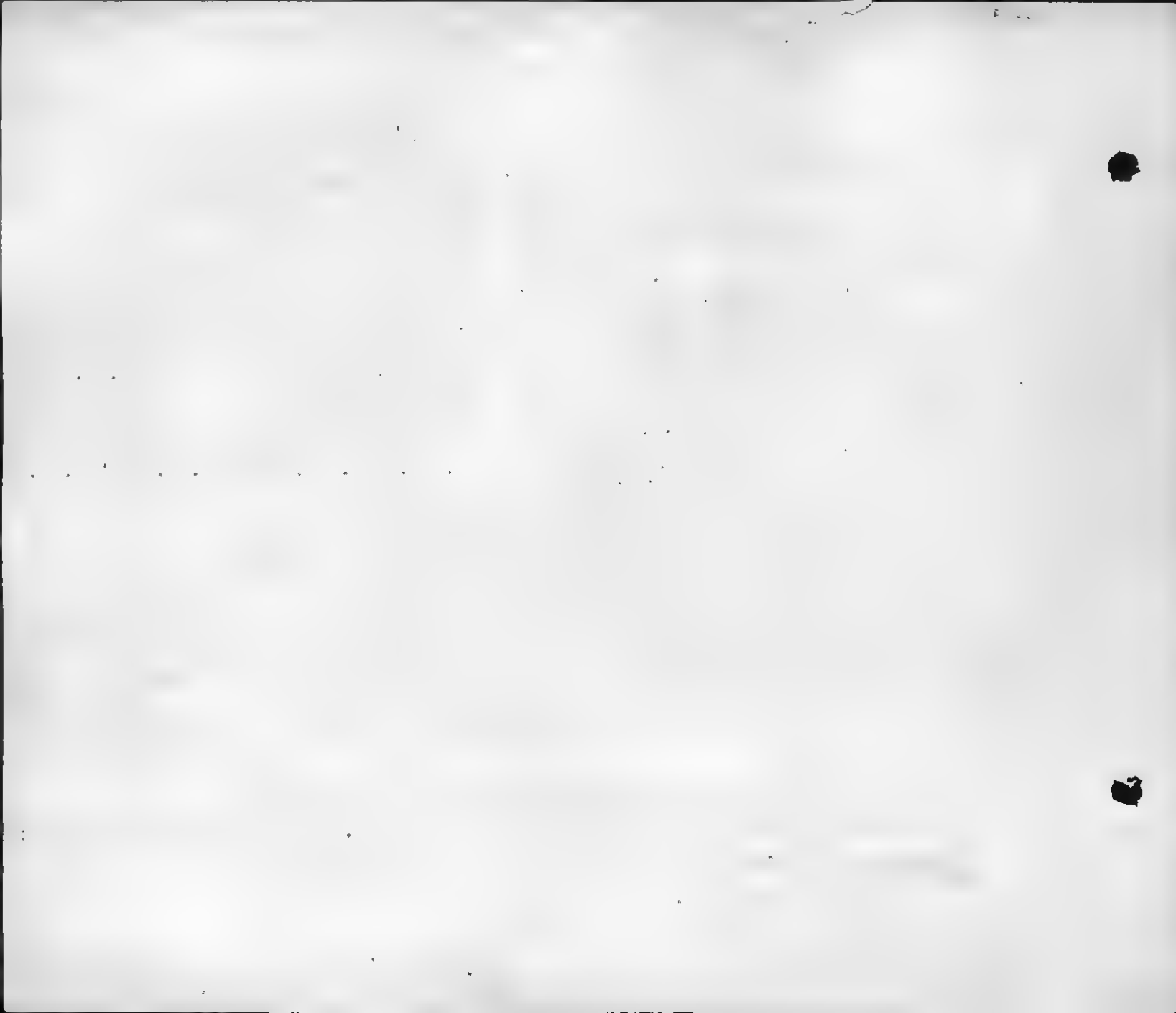
CERTIFICATE OF DEATH

Reg. Dist. No. *XX*

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
<i>X</i> TOWN <u>Fort Howard</u>		<u>4 Days</u>		TOWN <u>Baltimore</u> <i>31-1-14</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>6218 Shipview Way</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>GEORGE Richards SMITH</u>				<u>March 25, 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>August 20, 1891</u>	<u>63</u> yrs.	Months Days	Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>House Painter</u>				<u>Baltimore, Maryland</u>		<u>U. S. A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>William S. Smith</u>				<u>Nellie Gorsuch</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>WW-I</u>				16. SOCIAL SECURITY NO. <u>219-03-6830</u>			
				17. INFORMANT & ADDRESS. <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</u>			
15. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420.1</u>							
IMMEDIATE CAUSE							
(A) <u>MYOCARDIAL INFARCTION</u>						<u>UNKNOWN</u>	
DUE TO <u>ARTERIOSCLEROSIS OF CORONARY ARTERIES</u>							
ANTECEDENT CAUSE (S)							
(B) <u>WITH THROMBOSIS</u>						<u>UNKNOWN</u>	
DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)	
				INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
<u>VA</u>							
22. I hereby certify that I attended the deceased from <u>March 21, 1955</u> , to <u>Mar. 25, 1955</u> , and that death occurred at <u>5:45AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William B. VanDeGrift, M.D.</u>				ADDRESS <u>M. D. VAH, Fort Howard, Maryland</u>			
DATE SIGNED <u>3-25-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Mar. 28 1955</u>		<u>Wards Chapel Cemetery</u>		<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
<u>3-28-55</u>		<u>Wm. T. Tackner</u>		<u>Wm. Tackner &amp; Sons Funeral Home</u>			
				<u>North &amp; Pennsylvania Aves., Baltimore, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2462

*County*  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. ....

## 1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address *Smith Ave. Balto*
- (c) Hospital or institution: *md.*
- (d) Length of stay in hospital or inst. (yrs., mos., or days) *00*
- (e) Length of stay in Baltimore (yrs., mos., or days) *County 1*

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State *md* (b) County *Balto.*
- (c) City or town *Smith Ave., Balto. 9, md*  
(If outside city or town limits, write RURAL and give town)
- (d) Street No. *Smith Ave.*  
(If rural give location)
- (e) Citizen of foreign country? *no* (Yes or No)  
If yes, name country

3 (a) FULL NAME *Mitchell Benjamin Smith*3 (b) If veteran, name war *no*3 (c) Social Security Account  
No. *255-01-0621*4. Sex *M* 5. Color or race *W* 6 (a) Single, married, widowed, or divorced. *M*6 (b) Name of husband or wife *Margaret Christine*  
6 (c) If alive, give age *37* years7. Birth date of deceased (mo., day, yr) *July 14, 1889?*8. AGE: Years *65* Months *8* Days *4* If less than one day  
hr. min.9. Birthplace *Sullivan County, Tenn.*  
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *HENRY SMITH*

13. Birthplace

14. Maiden Name?

15. Birthplace

16 (a) Informant *Wife*

(b) Address

17 (a) *BURIAL* (b) Date thereof *3 21 55*  
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *MT OLIVE*  
Location *RANDALLS TOWN MD*18 (a) Funeral director *FRANK H NEWELL*(b) Address *Pikeville MD*19 (a) *MARCH 18, 1955* (b) *Kerathya Newell*  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *18 March* 1955, at *11 A.* M21. I certify that death occurred on the date above stated; that I attended deceased from *18 March* 1955, to *18 March* 1955, and that I last saw him alive on *18 March* 1955.

Immediate cause of death

*Coronary thrombosis*

Duration

*1 day*

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?  
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public place?  
(Specify type of place) While at work?

(e) Means of injury

23. Signature *Charles H. Williams, M.D.*  
M. D.Address *Pikeville 8, Md.* Date signed

## INSTRUCTIONS FOR MEDICAL CERTIFICATION

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### WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

### DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

### DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

### DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

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For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

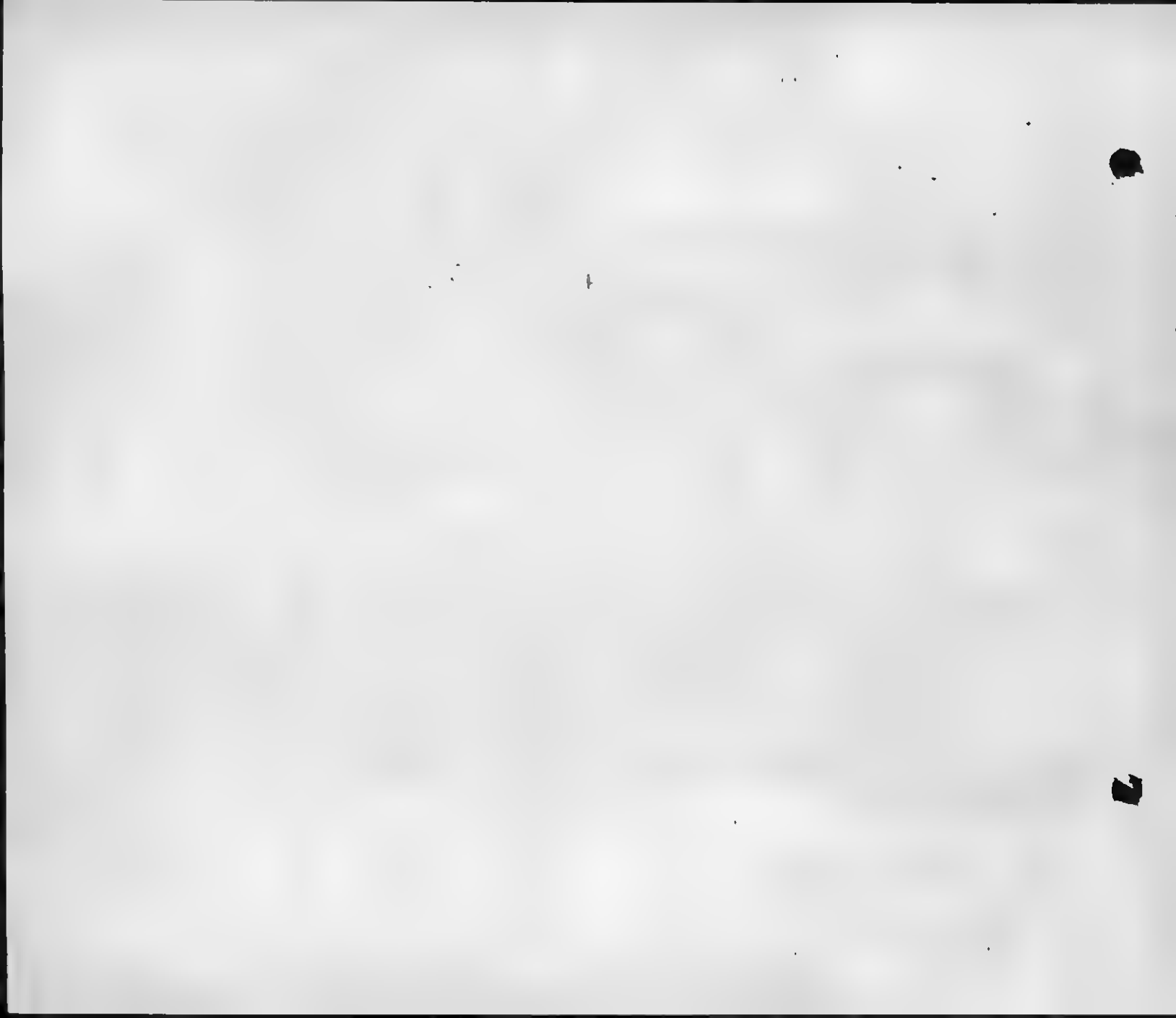
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2463

02447

## CERTIFICATE OF DEATH

Reg. Dist. No. 00

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Hyde</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Hyde</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100 Broadway</u>				STREET ADDRESS (If rural give location) <u>Bottom Rd</u>			
3. NAME OF DECEASED: (Type or Print) <u>Samuel Eugene Smith</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Mar 28 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>Jan 29-1887</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired oil distributor</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>oil</u>		11. BIRTHPLACE (State or foreign country): <u>Florida - Georgia</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME: <u>James E. Smith</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Lulu Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Russell J. Jones - father</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma of right lung</u>							
ANTECEDENT CAUSE (B) <u>Lung</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 5, 1954</u> to <u>Mar 25, 1955</u> , that I last saw the deceased alive on <u>Mar 25, 1955</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>William M. Hammett</u>		M. D. <u>Baldwin</u>		DATE SIGNED <u>10-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-1-55</u>		<u>Pleasant Hope Baptist</u>		<u>Baltimore - Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
				<u>Wm. Cook &amp; Co.</u>		<u>1217 S. Howard St.</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2464

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02448

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> OR TOWN <u>15</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>6602 Mt. Vernon av., Balto.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6602 Mt. Vernon av.</u>		STREET ADDRESS (If rural give location) <u>6602 Mt. Vernon av.</u>	
3. NAME OF DECEASED (Type or Print) <u>John</u> (First)	<u>T.</u> (Middle)	<u>Snead</u> (Last)	4. DATE OF DEATH (Month) <u>March</u> (Day) <u>3</u> (Year) <u>1955</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>August 29, 1875</u>
9. AGE last birthday <u>81</u> yrs.		10. AGE last birthday If under 1 year: Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min. <u>55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>Madison Co., Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Thomas Snead</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
332X Immediate cause (a) <u>Cerebral Thrombosis</u>			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Generalized arteriosclerosis</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Aneurysm, abdominal aorta.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office hldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 27, 1954</u> , to <u>3 March, 1955</u> , that I last saw the deceased alive on <u>1 March, 1955</u> , and that death occurred at <u>3:30 A.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Charles H. Williams, M.D.</u>		ADDRESS <u>Pikesville 8, Md.</u> DATE SIGNED <u>3 March '55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3-5-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Lorraine Memorial</u>		LOCATION (City, town, or county) <u>Baltimore Md.</u>	
DATE REC'D BY LOCAL REG. <u>March 3, 1955</u>		REGISTRAR'S SIGNATURE <u>Howthyd. Newell</u>	
24. FUNERAL DIRECTOR <u>Frank H. Newell</u>		ADDRESS <u>Pikesville Md.</u>	

BUREAU V. S.

1901

1901

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

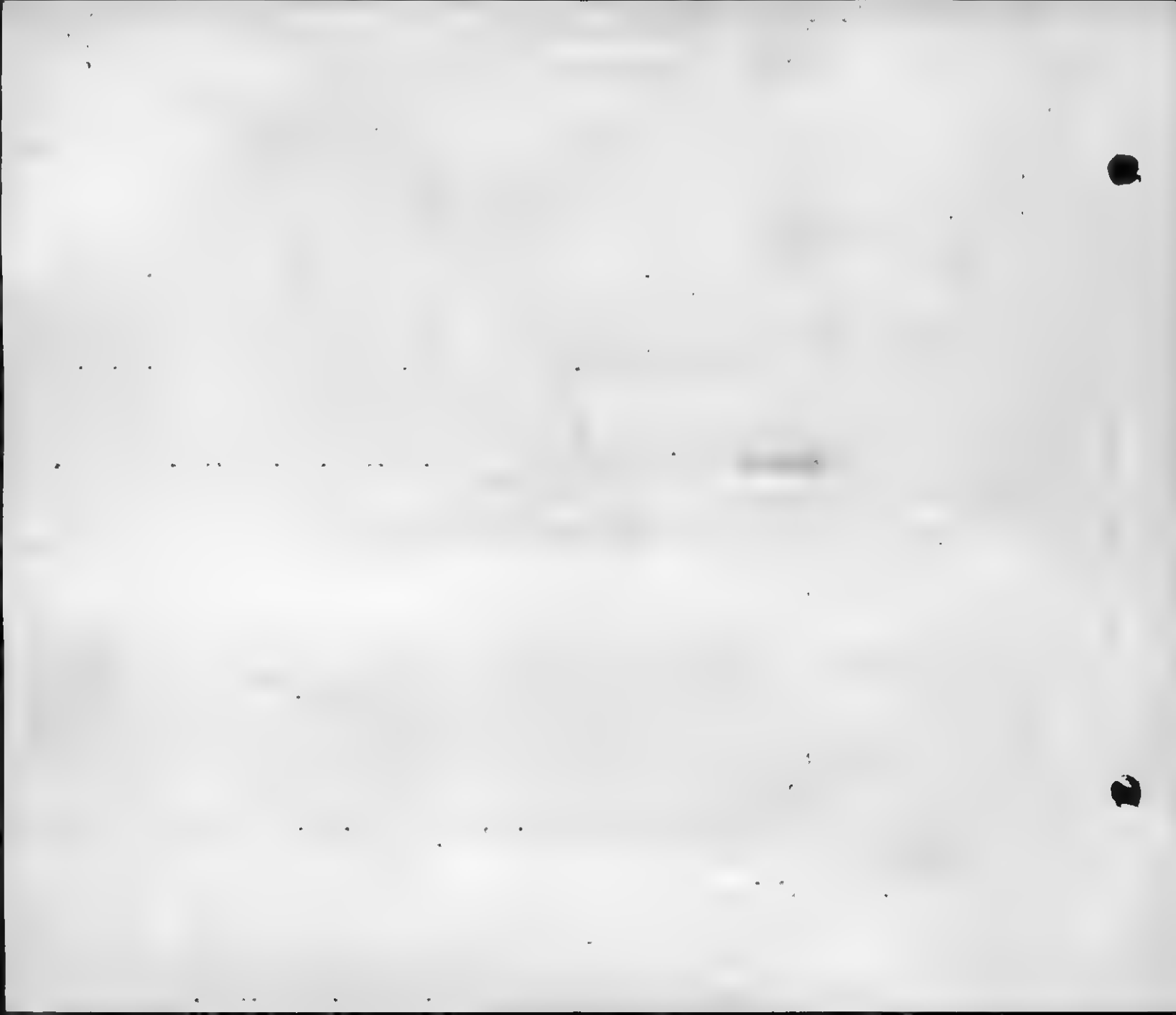
02449

2465

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>1</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort Howard</u>		221 Days		OR TOWN <u>Baltimore</u> 27 51			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>6907 Athol Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <u>JOHN J. SOBIESKI</u>				OF DEATH <u>March 29, 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	MARRIED	5/18/99	55 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Guard</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Maritime Comm.</u>		11. BIRTHPLACE (State or foreign country): <u>Krahov, Poland</u>	
13. FATHER'S NAME: <u>Pete Sobieski</u>				14. MOTHER'S MAIDEN NAME: <u>Katrine MN: Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>WW-II 3rd</u>				16. SOCIAL SECURITY NO. <u>216-24-1599</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						UNKNOWN	
203X IMMEDIATE CAUSE (A) <u>MULTIPLE MYELOMA</u>							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
203X (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>DIABETES MELLITUS</u>						UNKNOWN	
19A. DATE OF OPERATION: <u>8/27/54</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Findings: Plasma cell myeloma of bone. Laminectomy T-4 and Biopsy of Tumor</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 20, 19 54</u> to <u>Mar. 29, 19 55</u> , that I last saw the deceased <u>XXXXXX</u> , and that death occurred at <u>5:45 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Francis G. Dickey</u>		ADDRESS <u>VAH, FORT HOWARD, MARYLAND</u>					
DATE SIGNED <u>3/30/55</u>		DATE SIGNED					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-2-55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus Cemetery</u>		LOCATION (City, town, or county) (State) <u>Dundalk, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-30-55</u>		REGISTRAR'S SIGNATURE <u>R. C. Weber</u>		24. FUNERAL DIRECTOR <u>George Weber</u>		ADDRESS <u>105 S. Ann St., Balto., Md.</u>	





2466

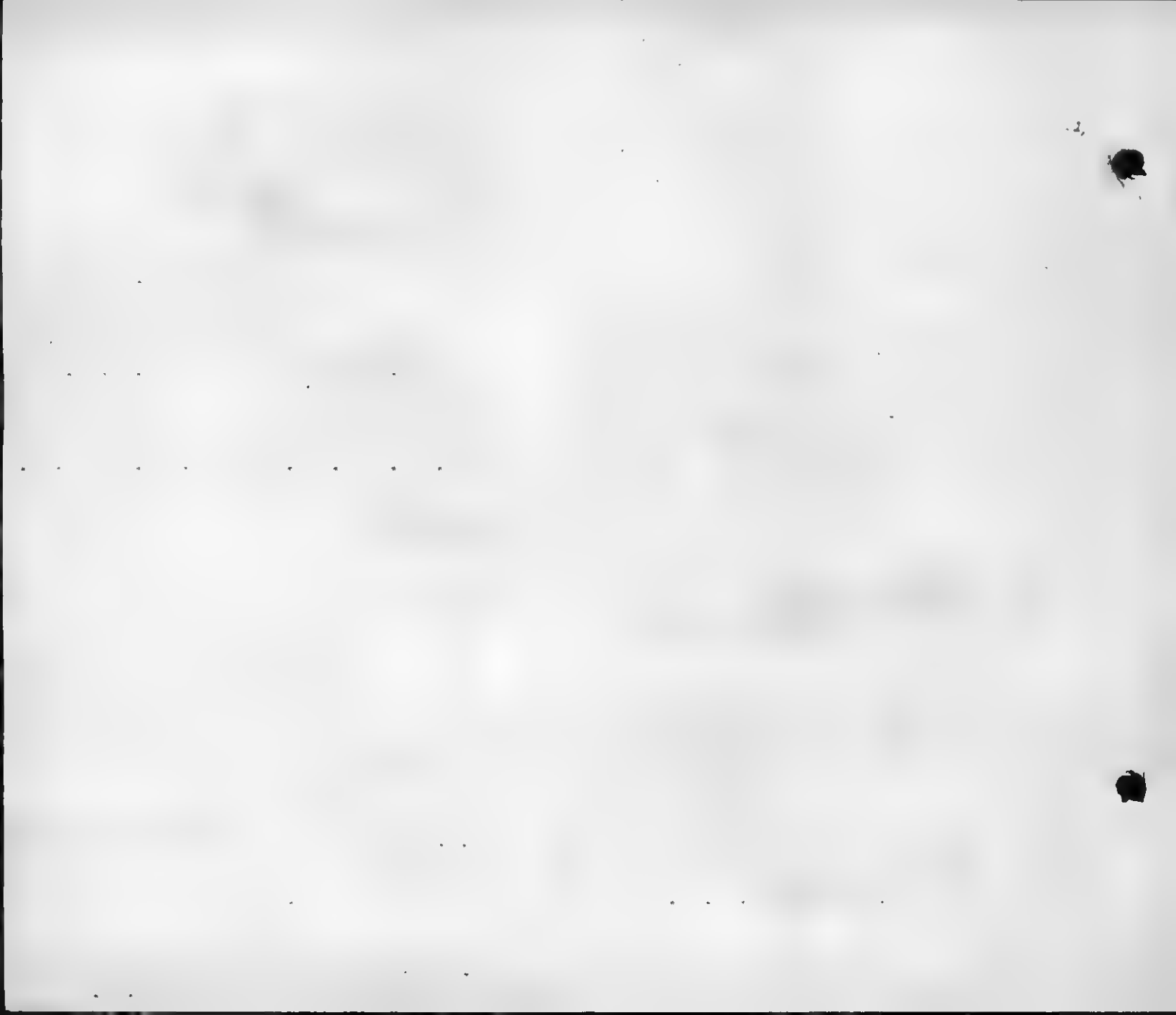
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Baltimore</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>L</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Fort Howard</b>	LENGTH OF STAY (in this place) <b>7 Days</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore, 4</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Veterans Administration Hospital</b>		STREET ADDRESS (If rural give location) <b>8727 Eddington Road</b>	
3. NAME OF DECEASED: (First) (Middle) (Last) <b>RUSSELL S. SPRECHER</b>		4. DATE (Month) (Day) (Year) OF DEATH <b>March 23, 1955</b>	
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH: <b>July 8, 1893</b>
9. AGE last birthday <b>61</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Flagman</b>	11. BIRTHPLACE (State or foreign country): <b>Mt. Airy, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME: <b>Charles G. Sprecher</b>	
14. MOTHER'S MAIDEN NAME: <b>Grace V. Harrison</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) <b>Yes</b> (If Yes, give war or dates of service) <b>WW-I</b>	
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT & ADDRESS: <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>BLEEDING ABDOMINAL ANEURYSM</b>			<b>7 DAYS</b>
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <b>3-19-55</b>		19B. MAJOR FINDINGS OF OPERATION: <b>Aortic Graft</b>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>March 16, 1955</b> , to <b>March 23, 1955</b> , and that death occurred at <b>11:45 M.</b> from the causes and on the date stated above.			
SIGNATURE <b>William B. VandeGrift, M.D.</b>		DATE SIGNED <b>March 24, 1955</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Mar. 28, 1955</b>	
NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>March 26, 1955</b>		REGISTRAR'S SIGNATURE <b>R.W.</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Blight Funeral Home</b>		ADDRESS <b>6009 Harford Road, Baltimore 14, Md.</b>	

MARGIN RESERVED FOR FILING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2467

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)		1	
14 <u>Spring Grove State Hospital</u>				<u>99 Dundalk Ave</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) (Middle) (Last)				OF DEATH: 3. 8 1955			
<u>Homer P. Squires</u>							
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>		8. DATE OF BIRTH: <u>Oct. 4 1876</u>	
				9. AGE last birthday: <u>78</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:			
<u>Apprentice</u>				<u>Home</u>			
11. BIRTHPLACE (State or foreign country): <u>unknown</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME: <u>unknown</u>				14. MOTHER'S MAIDEN NAME: <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT & ADDRESS: <u>CHLOE F. SQUIRES - SAME ADDRESS</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
490X IMMEDIATE CAUSE (A) <u>Lobar Pneumonia</u>						5 days	
DUE TO							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
DUE TO							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						years	
<u>Arteriosclerotic heart disease</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/6</u> , 19 <u>55</u> , to <u>3/8</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/8</u> , 19 <u>55</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Stella Wachler</u>				ADDRESS <u>M. D. Spring Grove State Hospital</u>		DATE SIGNED <u>3/8/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>3-11-55</u>		<u>MORELAND MEM. PK.</u>		<u>BALTO. CO. Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3/11/55</u>		<u>V.E. Harry</u>		<u>William B. Chaskey</u>		<u>Dundalk 22, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND

STATE DEPARTMENT OF HEALTH

02452

2468

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

Item 9, Film G179 4-5-55 et

1. PLACE OF DEATH- COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>BALTO.</u>			
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>BROOKLANDVILLE</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLANDVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VILLA GUARDIA</u>				STREET ADDRESS (If rural, give location) <u>VALLEY ROAD.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>SISTER MARIE MARTINA STANKARD</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 20, 1955</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>		8. DATE OF BIRTH <u>OCT. 24, 1906</u>	
9. AGE last birthday <u>48</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS</u>		9. AGE last birthday <u>48</u> yrs.	
11. BIRTHPLACE (State or foreign country) <u>MASS.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>MARTIN STANKARD</u>				14. MOTHER'S MAIDEN NAME <u>MARY FIEDRINE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)				16. SOCIAL SECURITY No.			
17. INFORMANT AND ADDRESS <u>Valley Public Works - Valley Rd.</u>				18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
2.1X Immediate cause (a)...				Hodgkins Disease			
Antecedent cause(s) (b)...				5 yrs.			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)...							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)				PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY m.				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>			
HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <u>Ap</u> , 19 <u>53</u> , to <u>March</u> 19 <u>55</u> , that I last saw the deceased alive on <u>Mar 19</u> , 19 <u>55</u> , and that death occurred at <u>4:15A</u> m., from the causes and on the date stated above.							
SIGNATURE <u>Harold H Burns</u>				ADDRESS <u>115 E Dager St Balto</u>			
DATE SIGNED <u>3/21/55</u>							
23. BURIAL, CREMATION REMOVAL (Specify) <u>burial</u>				NAME OF CEMETERY OR CREMATORY <u>Trinity Convent Cem.</u>			
DATE <u>3-22-55</u>				LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>3/31/55</u>				24. FUNERAL DIRECTOR <u>Dorley Funeral Home, Catonsville, Md.</u>			

Burns

43 02018

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

2469

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Stonelaugh</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>807 Kingston Road</u>				STREET ADDRESS (If rural, give location) <u>807 Kingston Rd.</u>			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Louis</u>		<u>Biddle</u>		<u>March 3, 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>Nov. 20, 1900</u>	
				9. AGE last birthday: <u>54</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>High School</u>		11. BIRTHPLACE (State or foreign country): <u>Kansas City, Mo.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Dr. Herbert Taylor Stephens</u>				14. MOTHER'S MAIDEN NAME: <u>Emma West Johnston</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mrs. James L. Sudborough 807 Kingston Rd.</u>			

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

175X  
Immediate cause(a) Intestinal obstruction  
DUE TO

INTERVAL BETWEEN ONSET AND DEATH

1 year

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Carcinoma of the ovary  
DUE TO2 years

(c)

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death. none

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

August 27, 1953 Carcinoma of left ovary with metastases

## 20. AUTOPSY?

Yes ☐ No ☒

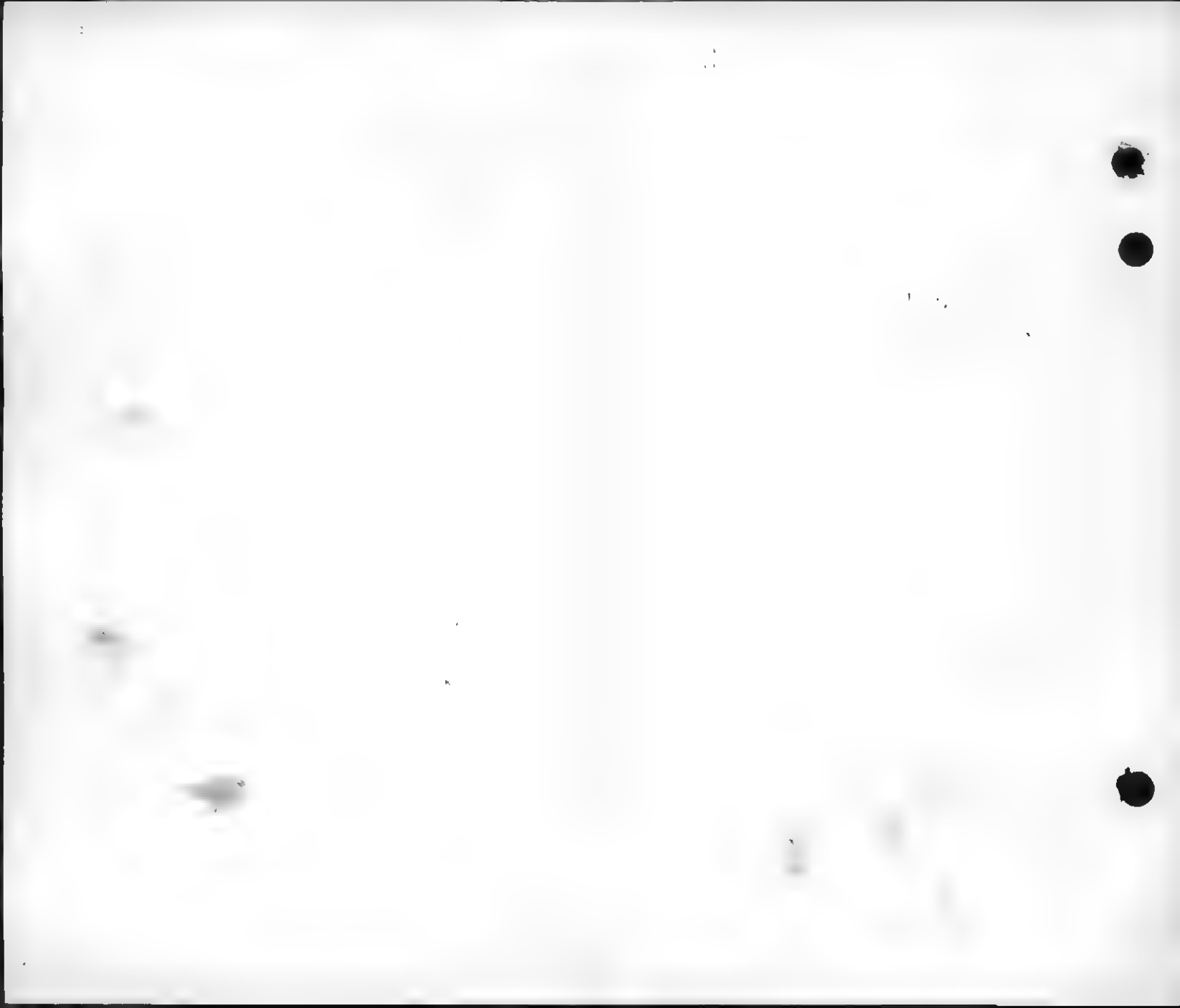
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)	
SUICIDE		HOMICIDE		<u>none</u>					
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?					
OF INJURY		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							

22. I hereby certify that I attended the deceased from August 1953, to March 3, 1955, that I last saw the deceased alive on March 3, 1955, and that death occurred at 9:10 A.M., from the causes and on the date stated above.

SIGNATURE <u>A.S. Chaffant, M.D.</u>		(DEGREE OR TITLE)		ADDRESS <u>6210 York Road</u>		DATE SIGNED <u>March 3, 1955</u>	
23. BURIAL, CREMATION REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>March 5, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		LOCATION (City, town, or county) <u>Pikesville, Md.</u>	
DATE REC'D BY LOCAL REG. <u>3/3/55</u>		REGISTER'S SIGNATURE <u>A.W. Hedrick</u>		24. FUNERAL DIRECTOR <u>John O. Mitchell</u>		ADDRESS <u>1900 Eutaw Rd.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2317		02454	
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 41			
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR and give nearest town	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR	TOWN
<u>53</u> <u>Baltimore</u> <u>22</u>	<u>1 year.</u>	<u>Dundalk</u> <u>22</u> <u>53</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1834 Portship Road.</u>		STREET ADDRESS <u>1834 Portship Rd.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>Kenneth Earl Stevens</u>		<u>Mar 28 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (State)	8. DATE OF BIRTH: <u>June 9/1908</u> <u>46</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		11. BIRTHPLACE (State or foreign country):	
<u>Electrician</u>		<u>City of Philadelphia, Pa.</u>	
13. FATHER'S NAME: <u>Arthur Stevens</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Reiningier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>169-05-6104</u>	
<u>No</u>		17. INFORMANT & ADDRESS: <u>Geneva Stevens-1834 Portship-Dundalk</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		18. MEDICAL CERTIFICATION	
<u>420.1</u>		<u>Coronary occlusion</u>	
Immediate cause (a) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>	
Antecedent cause(s) (b) DUE TO			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21d. TIME (Month) (Day) (Year) (Hour) OF <u>March 3-28-55 2 P.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .		21f. HOW DID INJURY OCCUR?	
SIGNATURE <u>W. M. Barmine M.D.</u>		M. D. <u>DEPUTY MEDICAL EXAMINER</u> <u>3/28/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>3/30/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>		LOCATION (City, town, or county) (State) <u>Baltimore 22, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>March 28-1955</u>		24. FUNERAL DIRECTOR <u>Walter Brooks Bradley, Inc.</u> ADDRESS <u>Dundalk 22 Maryland</u>	
REGISTRAR'S SIGNATURE <u>William M. Kelly</u>			



2470

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: <b>Towson</b>			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <b>Baltimore</b>		STATE <b>Maryland</b>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>55 TOWNS</b>		LENGTH OF STAY (in this place) <b>1 yr. 9 mos. 25 d.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>311.4 TOWN Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>B Sheppard &amp; Enoch Pratt Hosp. Towson 4, Maryland</b>		STREET ADDRESS <b>101 W. Monument St.</b>		(If rural give location)	
3. NAME OF DECEASED: (First) <b>Margaret</b> (Middle) <b>Talbot</b> (Last) <b>Stevens</b>			4. DATE OF DEATH: (Month) <b>3</b> (Day) <b>30</b> (Year) <b>1955</b>		
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>single</b>	8. DATE OF BIRTH: <b>Feb. 6, 1892</b>		
9. AGE last birthday: <b>63</b> yrs.			10. MONTHS <b>3</b> DAYS <b>30</b> HOURS <b>1955</b> MIN.		
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <b>Librarian</b>			10b. KIND OF BUSINESS OR INDUSTRY: <b>B. &amp; O. Rail Road</b>		
11. BIRTHPLACE (State or foreign country): <b>Anne Arundel Co., Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME: <b>Thomas Eddy Stevens</b>			14. MOTHER'S MAIDEN NAME: <b>Id. Isabel Talbot</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>			16. SOCIAL SECURITY No.: <b>(If Yes, give war or dates of service)</b>		
17. INFORMANT & ADDRESS: <b>Hospital records</b>					

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
355X Immediate cause (a) <b>Broncho pneumonia</b>		<b>Term</b>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <b>Diffuse cerebral atrophy (cause unknown)</b>		<b>2 yr +</b>
(c) <b>Chronic Brain Syndrome of Unknown origin &amp; psychosis</b>		<b>2 yr +</b>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

21. ACCIDENT (Specify) <b>SUICIDE</b>	PLACE (Home, farm, factory, street, office bldg., etc.) <b>HOMICIDE</b>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

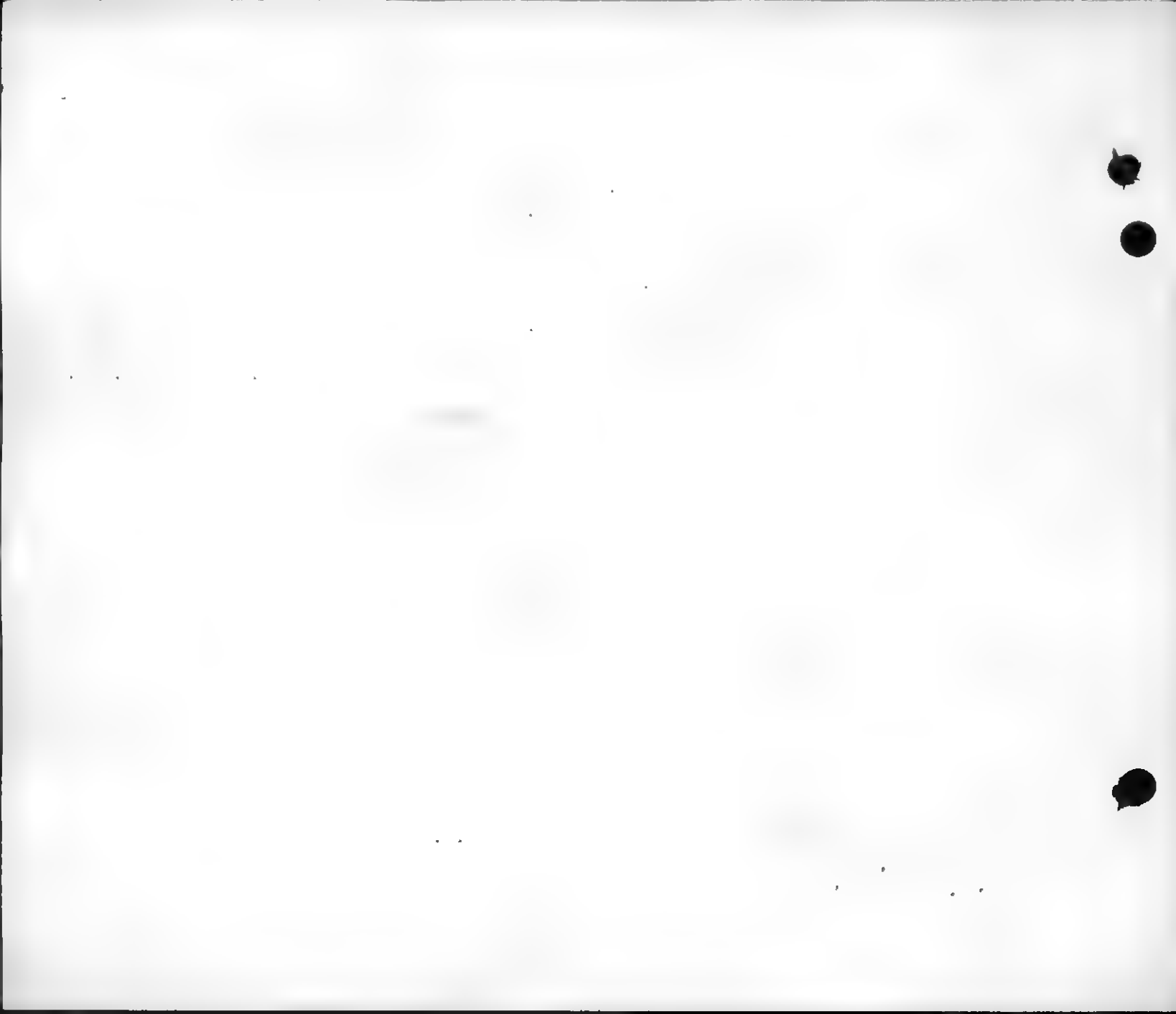
22. I hereby certify that I attended the deceased from **June 5, 1953**, to **March 30, 1955**, that I last saw the deceased alive on **March 30, 1955**, and that death occurred at **3:00 p.m.**, from the causes and on the date stated above.

SIGNATURE **William M. D.** DATE SIGNED **3/30/55**  
 (Degree or title) **Assistant Medical Supt., Sheppard-Pratt Hospital**

23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>April 2, 1955</b>	NAME OF CEMETERY OR CREMATORY <b>Methodist Church Cem.</b>	LOCATION (City, town, or county) <b>Davidsonville, A. A. Co., Md.</b>
DATE REC'D BY LOCAL REGISTRAR <b>3-31-55</b>	REGISTRAR'S SIGNATURE <b>A. A.</b>	FUNERAL DIRECTOR <b>Hedrick John O. Mitchell &amp; Sons Inc.</b>	ADDRESS <b>1900 Eutaw Place</b>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2471

2411 N. Charles Street, Baltimore

02456

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Overlea, Baltimore</u>	
TOWN <u>Overlea</u>		TOWN <u>Overlea, Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>701 Elmwood Road</u>		STREET ADDRESS (If rural, give location) <u>701 Elmwood Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Elizabeth</u>		(Last) <u>Streb</u>	
4. DATE OF DEATH <u>March 17, 1955</u>		(Year) <u>19</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>Dec. 13, 1874</u>	
9. AGE last birthday <u>80</u> yrs.		If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Krastel</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Bunn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Robert J. Streb 701 Elmwood Road</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
331X Immediate cause (a) <u>cerebral hemorrhage with osclerosis</u>			<u>3 days</u>
Antecedent cause(s) (b) <u></u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u></u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 13, 1953</u> , to <u>March 17, 1955</u> , that I last saw the deceased alive on <u>March 17, 1955</u> , and that death occurred at <u>5 P.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>3-18-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>March 21, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>18-55</u>		24. FUNERAL DIRECTOR ADDRESS <u>Lilly &amp; Zeiler Inc., 403 S. Wolfe St.</u>	



2472

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Balto.</u> MARYLAND			STATE <u>Md.</u> COUNTY <u>Balto.</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> TOWN <u>Woodlawn</u>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Woodlawn</u> <input checked="" type="checkbox"/>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>911 Masfield Rd.</u>			STREET ADDRESS (If rural give location) <u>911 Masfield Rd.</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>M. ETHEL STROM</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>Mar. 4, 1955</u>		
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>May 24, 1891</u>		
9. AGE last birthday: <u>63</u> yrs.			10. IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Teacher</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Nursery School</u>		
11. BIRTHPLACE (State or foreign country): <u>Ill.</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME: <u>Henry S. Noble</u>			14. MOTHER'S MAIDEN NAME: <u>Annie McGhee</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>4</u>		
17. INFORMANT & ADDRESS: <u>Mr. Harry G. Neuman-911 Masfield Rd. #7</u>					

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Myocardial infarction</u>		<u>5 min.</u>
ANTECEDENT CAUSE (B) <u>Arteriosclerotic heart disease</u>		<u>10 yrs.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Malignant hypertension</u>		<u>10 yrs</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

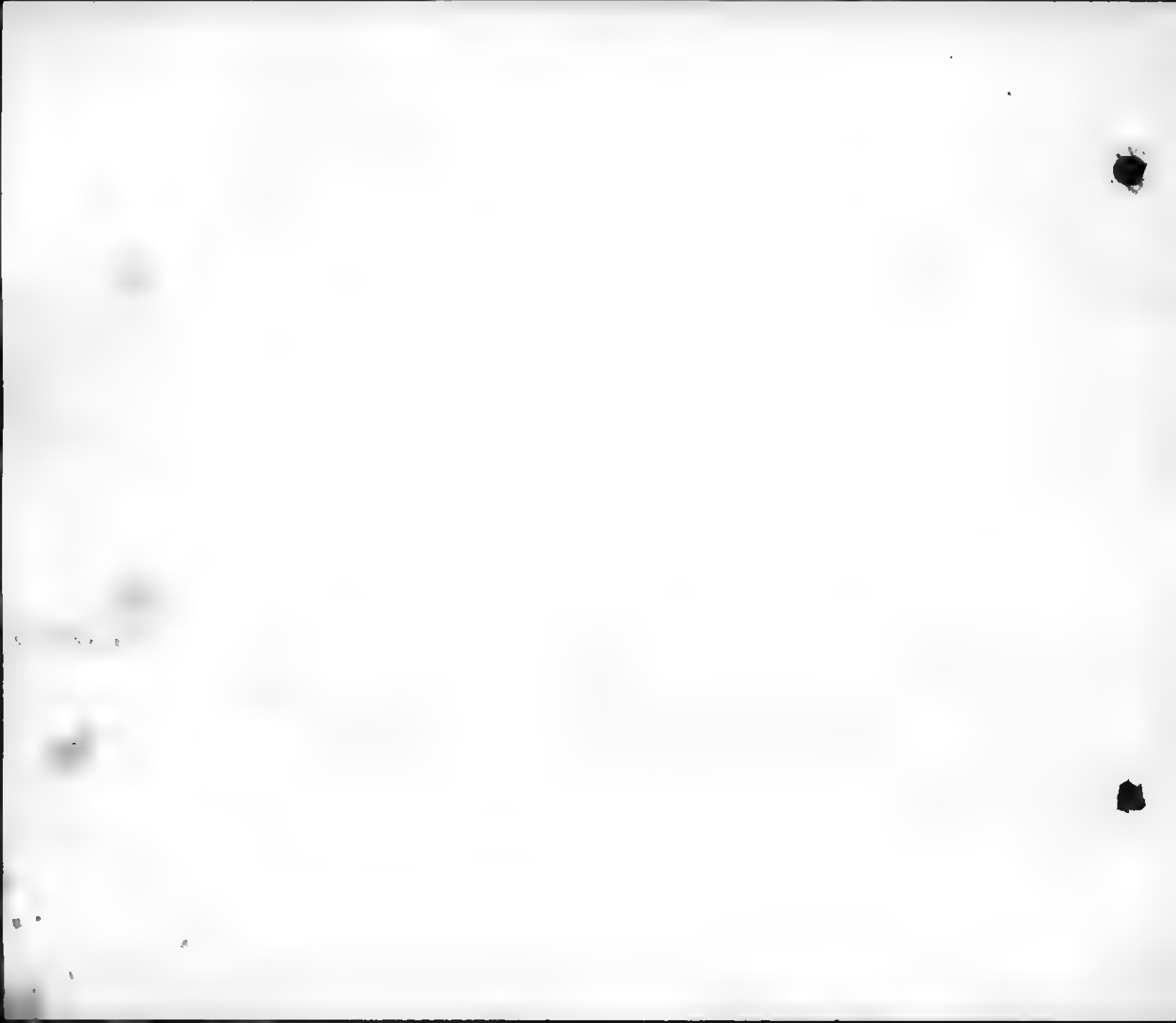
22. I hereby certify that I attended the deceased from May 25, 1954, to March 3, 1954, that I last saw the deceased alive on March 3, 1954, and that death occurred at 3:25 PM, from the causes and on the date stated above.

SIGNATURE Stephen J Van Lill Jr ADDRESS M.D. 2843 St. Paul DATE SIGNED St.

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
--	--------------	-------------------------------	--

DATE REC'D BY LOCAL REGISTRAR <u>3-4-55</u>	REGISTRAR'S SIGNATURE <u>Wm. J. Trickett</u>	ADDRESS <u>Baltimore 17 Md</u>
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MARGIN RESERVED FOR BINDING





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2473

02458

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Catonsville</u>	LENGTH OF STAY (In this place) <u>6yr. 8mo. 14 days</u>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	<u>516 S. Hanover St.</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>	STREET ADDRESS <u>Seton Institute</u>	(If rural, give location) <u>3v01-4</u>	
3. NAME OF DECEASED: (Type or Print)	(First) <u>Anton</u>	(Middle)	(Last) <u>Sulovsky</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>5-27-1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Blacksmith</u>	10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: <u>65</u> yrs.	4. DATE OF DEATH <u>March 16, 1955</u>
11. BIRTHPLACE (State or foreign country): <u>Czechoslovakia</u>	12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	13. FATHER'S NAME: <u>Jon Sulovsky</u>	
14. MOTHER'S MAIDEN NAME: <u>Anna Parfreakova</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Unknown</u>	16. SOCIAL SECURITY No.: <u>Unknown</u>	17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
<u>420.1</u> Immediate cause (a) <u>Pericardial Tamponade due to</u> DUE TO <u>Ruptured heart, Arterio sclerotic coronary</u> Antecedent cause(s) (b) <u>heart disease</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>Carl M. Kieffer</u> 1010 Kieffer St. CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAM. <u>Mar 16 55</u>		
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>Mar. 19/55</u>	NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cem.</u>
LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	DATE REC'D BY LOCAL REG. <u>3/19/55</u>	REGISTRAR'S SIGNATURE <u>V. E. Harry</u>
24. FUNERAL DIRECTOR <u>Harry H. Witzke</u>	ADDRESS <u>4101 Edmondson Ave.</u>	

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1961

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

02459

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>Baltimore</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7012 Beach Ave</u>		STREET ADDRESS (If rural, give location) <u>7012 Beach Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Carrie M Taaffe</u>		4. DATE OF DEATH <u>March 16 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Aug 22-1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	9. AGE last birthday <u>62</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Balto City md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Otto H Guertel</u>		14. MOTHER'S MAIDEN NAME <u>Lena Roehn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Metzold T. Taaffe 7012 Beach Ave</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
340 Immediate cause (a) <u>Cortic. Respiratory Infection</u>		<u>4 days</u>
Antecedent cause(s) (b) <u>Multiple Sclerosis</u>		<u>year</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1954, to March 16, 1955, that I last saw the deceased alive on 3-15, 1955 and that death occurred at 8 A m., from the causes and on the date stated above.

SIGNATURE William L. Feary MD ADDRESS 3025 Belair Road DATE SIGNED 3-16-55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Funeral Home</u>	<u>3/19/55</u>	<u>Parkwood Cem</u>	<u>Balto md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>17</u>	<u>W. L. Feary</u>	<u>William L. Feary</u>	<u>Funeral Home 2401 Belair Rd</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3025 15-10-10

1 10-10-10

02460

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. **32**

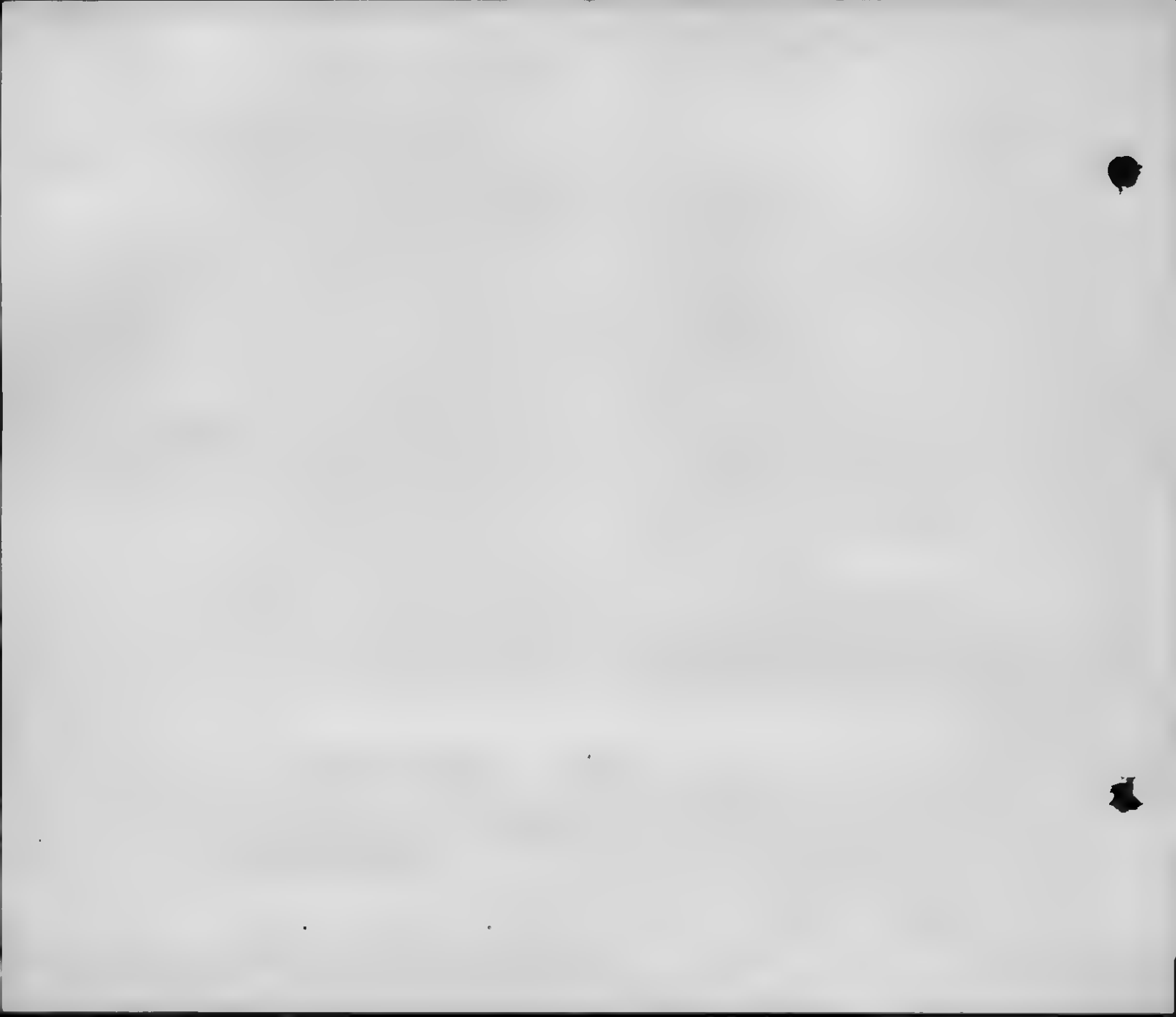
Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Balto.</b>	MARYLAND	STATE <b>Md.</b>	COUNTY <b>Balto.</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>X TOWN Pikesville</b>	LENGTH OF STAY (in this place) <b>12 yrs</b>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <b>Pikesville</b>	<b>X</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>4105 Lowell Drive</b>		STREET ADDRESS (If rural, give location) <b>4105 Lowell Drive</b>	<b>1</b>
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <b>PERCY</b>	(Middle) <b>BROWNE</b>	(Last) <b>THOMAS</b>	(Month) <b>Mar</b> (Day) <b>6</b> (Year) <b>1955</b>
5. SEX: <b>male</b>	6. COLOR OR RACE: <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH: <b>Jan 11, 1895</b>
9. AGE last birthday: <b>60</b> yrs.		10. IF UNDER 1 YEAR: Months Days	
11. BIRTHPLACE (State or foreign country): <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Frank F. Thomas</b>		14. MOTHER'S MAIDEN NAME: <b>Genevieve Browne</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No.</b>		16. SOCIAL SECURITY No.: <b>215-03-5370</b>	
17. INFORMANT & ADDRESS: <b>Kinden G. Apt.</b>		18. INFORMANT & ADDRESS: <b>Eugene D. Thomas (brother)</b>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <b>Coronary artery Disease</b>		5 mo.	
Antecedent cause(s) (b) <b>None.</b>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>None.</b>			
19a. DATE OF OPERATION: <b>None.</b>		19b. MAJOR FINDING OF OPERATION: <b>None.</b>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <b>no.</b>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <b>None.</b>	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>None. M.</b>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>None.</b>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <b>D. D. Caples</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>3-6-55</b>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Cremation</b>	DATE THEREOF: <b>3/9/55</b>	NAME OF CEMETERY OR CREMATORY: <b>Loudon Park Cem.</b>	LOCATION (City, town, or county) (State): <b>Balto., Md.</b>
DATE REC'D BY LOCAL REG. <b>3-7-55</b>	REGISTRAR'S SIGNATURE: <b>Q W Hedrick</b>	24. FUNERAL DIRECTOR: <b>Wm. J. Tidwell &amp; Sons</b>	ADDRESS: <b>Balto. Md.</b>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

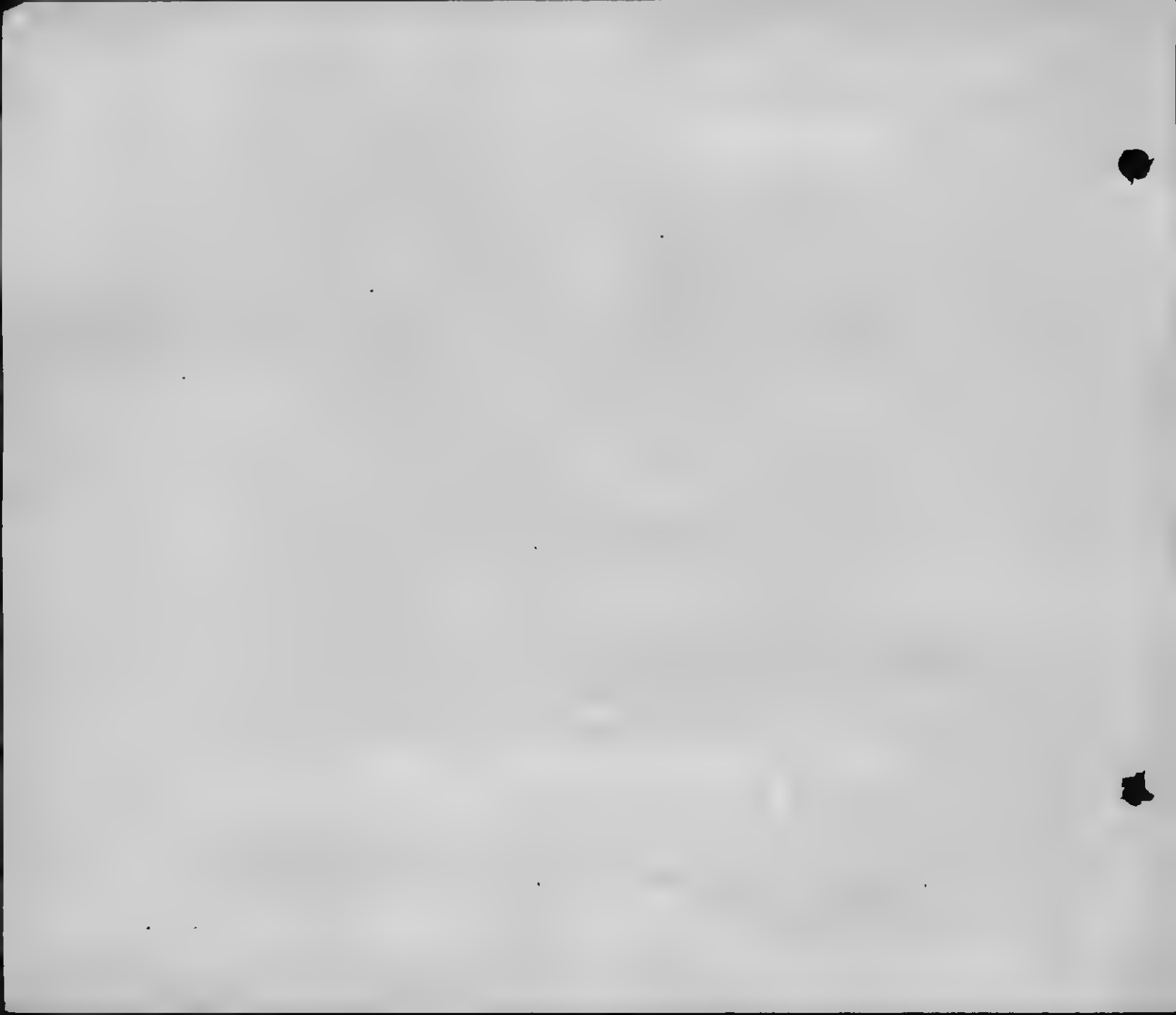
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	MARYLAND	STATE	Balto COUNTY Balto
CITY (If outside corporate limits, write name of town and give nearest town)	RURAL	CITY (If outside corporate limits write name of town and give nearest town)	Balto 21 (Middleborough)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	2241 Corsica Rd.	STREET ADDRESS	2241 Corsica Rd.
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First)	(Middle)	(Last)	(Month) (Day) (Year)
Eugene John Tonsignon		Mar 28 1955	
5. SEX:	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: 1902 AGE last birthday: 51 yrs.
Male	White	Married	25/1902 51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		11. BIRTHPLACE (State or foreign country):	
Engineer		Quebec Can. U.S.A.	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Joseph Tonsignon		Amanda	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.)		16. SOCIAL SECURITY No.:	
No		213-03-9992	
17. INFORMANT & ADDRESS:		Mrs. Franc Tonsignon (info).	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		18. MEDICAL CERTIFICATION	
Immediate cause		(a) ... DUE TO	
Antecedent cause(s)		(b) ... DUE TO	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c) ...	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>		21. MEDICAL CERTIFICATION	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.)	
21c. (City or town) (County) (State)		21d. TIME (Month) (Day) (Year) (Hour) (Minute)	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE		DATE SIGNED	
M. D.		M. D.	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF	
Burial		3/31/55	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Druid Ridge Cem.		Pikesville, Md.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR	
REG. 3-30-55		M. J. Tinkney & Sons	
ADDRESS		BALTO 17 Md	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





2477  
CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Rural - Millers</u>	<u>30 yrs.</u>	TOWN <u>Rural - Millers</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Beckleysville Rd.</u>		STREET ADDRESS (If rural give location)	<u>Beckleysville Rd.</u>
3. NAME OF DECEASED:	(First) (Middle) (Last)	4. DATE OF DEATH	(Month) (Day) (Year)
(Type or Print) <u>Harry Tracey</u>		<u>March 9, 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>August 6, 1872</u>
9. AGE last birthday: <u>82</u> yrs.		10. CITIZEN OF WHAT COUNTRY: <u>U. S. A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Farm.</u>	
11. BIRTHPLACE (State or foreign country): <u>Beckleysville, Md</u>		12. CITIZEN OF WHAT COUNTRY: <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Jacob Tracey</u>		14. MOTHER'S MAIDEN NAME: <u>Martha Egglinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>No</u>		16. SOCIAL SECURITY NO. <u>                    </u>	
17. INFORMANT'S NAME: <u>Mrs. Ethel Tracey - Millers</u>		17. INFORMANT'S ADDRESS: <u>                    </u>	

15. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
331X	(A) <u>Cerebral hemorrhage</u>	<u>40 hrs</u>
IMMEDIATE CAUSE	DUE TO	
ANTECEDENT CAUSE (S)	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO	
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/8, 1955, to 3/9, 1955, that I last saw the deceased alive on 3/9/55, 1955, and that death occurred at 11:30 PM, from the causes and on the date stated above.

SIGNATURE <u>A. M. France</u>	M. D. <u>                    </u>	DATE SIGNED <u>3/11/55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>	DATE THEREOF <u>3/12/55</u>	NAME OF CEMETERY OR CREMATORY <u>Middletown</u>
		LOCATION (City, town, or county) (State) <u>Middletown Balt Md</u>
DATE REC'D BY LOCAL REGISTRAR <u>3/12/55</u>	REGISTRAR'S SIGNATURE <u>Charles F. Frederick</u>	24. FUNERAL DIRECTOR <u>                    </u>
		ADDRESS <u>New Freedom Rd</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

1955

2478

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED.			
COUNTY <u>Baltimore</u> MARYLAND				STATE <u>Md.</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)				CITY (If outside corporate limits, write RURAL and give nearest town)			
OR and give nearest town)				OR			
X TOWN <u>Lutherville</u>				TOWN <u>Centerville</u> 11X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>College Manor Nursing Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>Agatha Wheeler Vest</u>				OF DEATH: <u>March 22 1955</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE MARRIED WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
female		white		widowed		Oct. 10, 1864	
9. AGE last birthday:		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
90 yrs.		housewife		Mississippi			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John Emory</u>				<u>Mary Conway Emmanuel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS:				Washington, D.C.			
<u>Mr. John. P. W. Vest - 1627 K St. N. W.</u>							
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>							5 year?
ANTECEDENT CAUSE (B) <u>Hypertension Cerebrovascular disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>3/15</u> 19 <u>55</u> , to <u>3/22</u> 19 <u>55</u> , that I last saw the deceased alive on <u>3/21</u> 19 <u>55</u> , and that death occurred at <u>10:55</u> PM, from the causes and on the date stated above.							
SIGNATURE <u>George S. Watson</u>				ADDRESS <u>114 St. Paul St. Balt. Md.</u>		DATE SIGNED <u>3/23/55</u>	
M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>March 23, 1955</u>		<u>Washington, D.C.</u>			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<u>3-23-55</u>		<u>R. W. Hyndrich</u>		<u>Wm. J. Lickner &amp; Sons - Balt. Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2479

CERTIFICATE OF DEATH

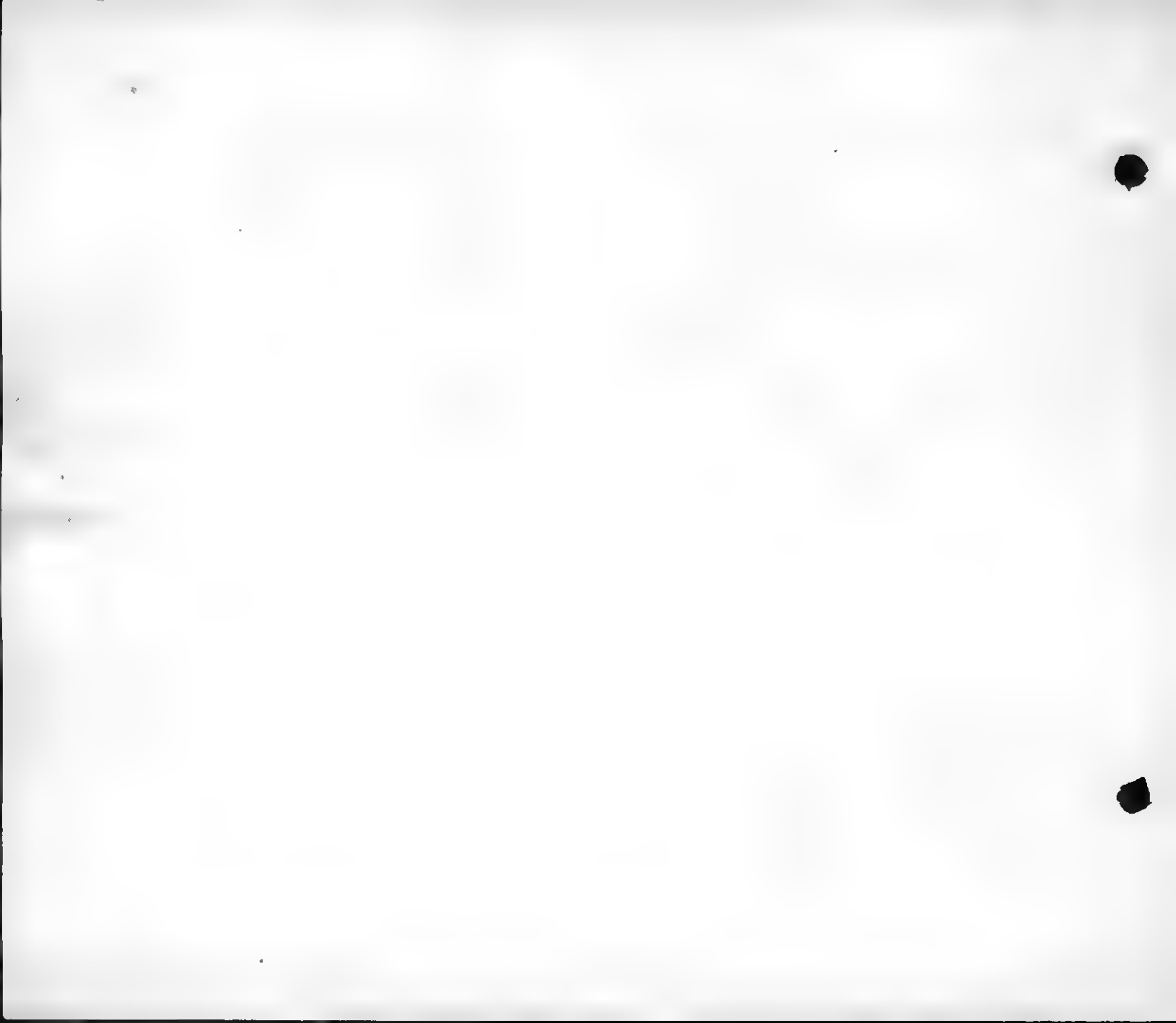
Reg. Dist. No.

38

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>55 TOWSON</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>41 Dunkirk Rd.</u>		STREET ADDRESS (If rural give location) <u>41 Dunkirk Rd.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
OLLIE M. VIESSMAN		DATE OF DEATH: Mar. 17, 19 55	
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: Oct. 7, 1876
		9. AGE last birthday: 78 yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY: at home	11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME: George Knellinger		14. MOTHER'S MAIDEN NAME: Elizabeth Bush	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no		16. SOCIAL SECURITY No. none	
17. INFORMANT & ADDRESS: Miss Ethel I. Viessman - 41 Dunkirk Rd.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>422.1 Cardiovascular disease</u>		<u>about 5 1/2</u>	
ANTECEDENT CAUSE (B) <u>Arteriosclerosis</u>		<u>9</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION.		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Oct 4, 1954, to March 17, 1955 that I last saw the deceased alive on Dec. March 7, 1955, and that death occurred at 9 <sup>00</sup> A.M. from the causes and on the date stated above.			
SIGNATURE <u>Thelma Stiller</u>		DATE SIGNED <u>Oct 15/55</u>	
ADDRESS <u>2220 Barron Blvd</u>		M.D. <u>2220 Barron Blvd</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/19/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>		LOCATION (City, town, or county) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-18-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
FUNERAL DIRECTOR <u>Wm. J. Lickner</u>		ADDRESS <u>1400 S. Ba...</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2318

## MARYLAND STATE DEPARTMENT OF HEALTH

02465

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

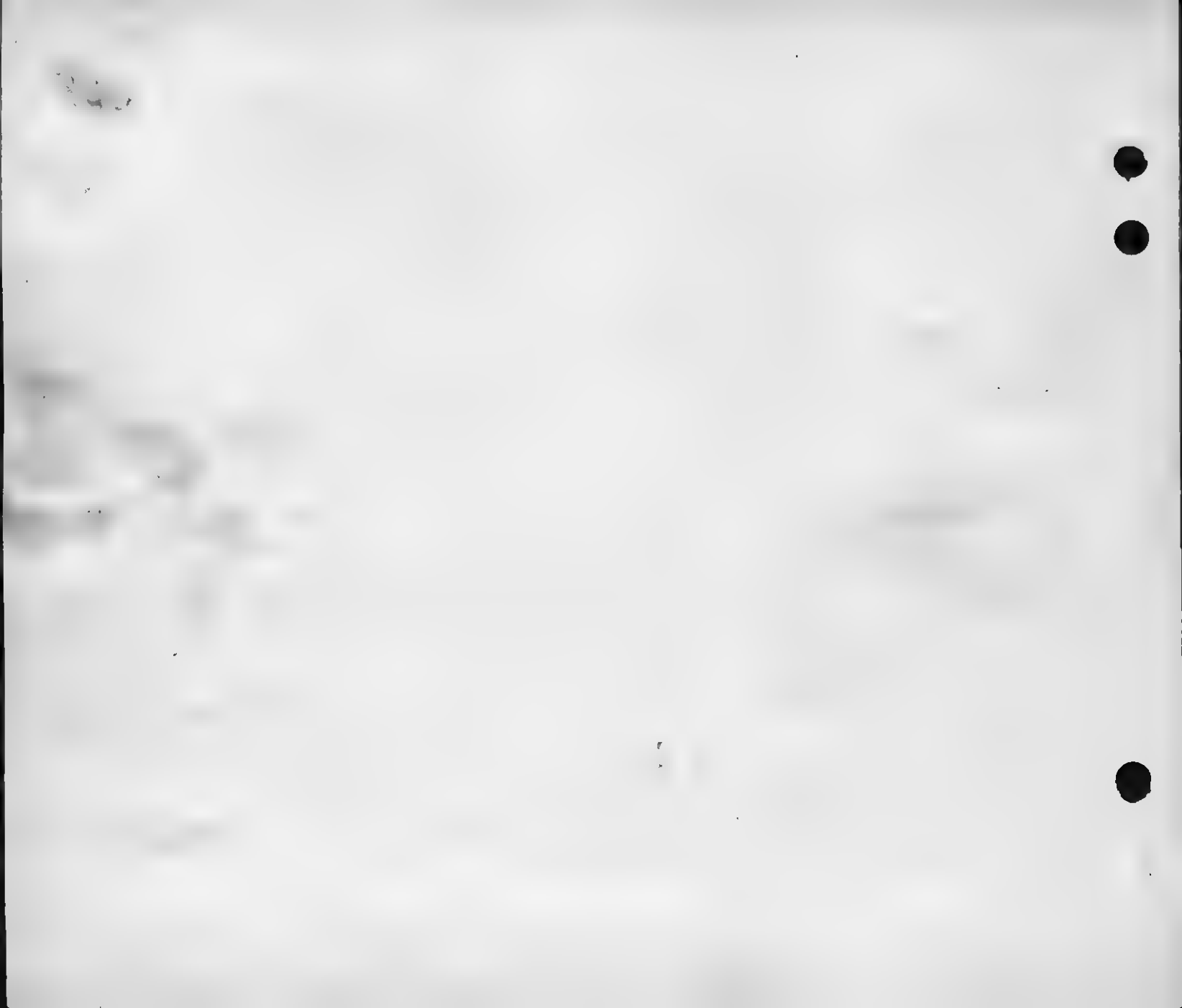
Reg. Dist. No. ....

Form 9, Fil. 6170 3-24-55 et

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk 22</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u> 101-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100 Barbeary Ct</u>		STREET ADDRESS (If rural, give location) <u>633 St. Mulberry St</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>OTIS</u> (Middle) <u>Hebsten</u> (Last) <u>Walker</u>	4. DATE OF DEATH (Month) <u>March</u> (Day) <u>17</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 10, 1893</u>
9. AGE last birthday <u>61</u> <u>62</u> yrs.		10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Store Clerk</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY No. <u>216-10-5768</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Marian E. Walker, 100 Barbeary Ct, Dundalk 22 Md</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) <u>Hypostatic Pneumonia</u> Antecedent cause(s) (b) <u>Cerebral Apoplexy</u> Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 yr</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>February 12, 1955</u> , to <u>March 17, 1955</u> , that I last saw the deceased alive on <u>March 17, 1955</u> , and that death occurred at <u>10:28</u> a.m., from the causes and on the date stated above.			
SIGNATURE <u>William C. Grade M.D.</u>		ADDRESS <u>140 Oak Avenue, Dundalk 22 Md</u>	
DATE SIGNED <u>3/17/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY <u>Balto. National</u>	
DATE TIME OF <u>3/21/55</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Charles R. Law</u>		ADDRESS <u>802 Madison Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





2480

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Charles	
CITY (If outside corporate limits, write RURAL and give nearest town) OR and give nearest town X TOWN Owings Mills				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN (Rural) Potomac Heights			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rosewood State Training School				STREET ADDRESS (If rural give location) 10 Kenwood Place			
3. NAME OF DECEASED:		(First) Michael		(Middle) Paul		(Last) Weeks	
(Type or Print)							
4. DATE OF DEATH:		(Month) 3		(Day) 27		(Year) 19 55	
5. SEX: male		6. COLOR OR RACE: white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single		8. DATE OF BIRTH: 8/12/47	
						9. AGE last birthday: 7 yrs.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): LaPlata, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Milton A. Weeks				14. MOTHER'S MAIDEN NAME: Ruby Elizabeth Byrd			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Rosewood Records, Owings Mills, Maryland			

18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
492X Immediate cause (a) an Aspiration Pneumonitis							
Antecedent causes (s) (b) DUE TO							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) DUE TO							
11. OTHER SIGNIFICANT CONDITIONS Congenital malformation of brain with mental deficiency, flacid paralysis and convulsive							
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION congenital disorder							
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
HOMICIDE		INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY 3 27 55 m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11/5/19 53, to 3/27/19 55, that I last saw the deceased alive on 3/27/19 55, and that death occurred at 12:45 p.m., from the causes and on the date stated above.							
SIGNATURE Viola B. Johns				ADDRESS Owings Mills, Maryland		DATE SIGNED 3/28/55	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF 3-30-55		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR 3-30-55		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
		Mary Elinor		Flannery & Co. Placid			

MARGIN RESERVED FOR BINDER

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The age is especially important. Physicians: please write the causes of death clearly and legibly.

STANDARD V. S.

APR 1

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02467  
2481 CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glyndon (Rural)</u> LENGTH OF STAY (in this place) <u>20 yrs.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Worthington Rd.</u>		STATE <u>Md.</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Glyndon (Rural)</u> STREET ADDRESS (If rural give location) <u>Worthington Rd.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>John Evan Wheeler</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>7-27-55</u> <u>19</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>3-27-1901</u>
9. AGE last birthday: <u>53</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Evan D. Wheeler</u>		14. MOTHER'S MAIDEN NAME: <u>Ida Skipper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no.</u>		16. SOCIAL SECURITY NO. <u>215-16-0040</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Dora Agnes Wheeler, Glyndon, Md.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>422.1</u>		<u>10 mo.</u>	
ANTECEDENT CAUSE (S)		<u>2 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		<u>10 mo.</u>	
(A) <u>Cardiac Decompensation</u>			
(B) <u>arteriosclerotic C.-V. Disease</u>			
(C) <u>Left Bundle Branch Block.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Renal insufficiency.</u>		<u>9 days.</u>	
19A. DATE OF OPERATION: <u>none.</u>		19B. MAJOR FINDINGS OF OPERATION: <u>none.</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>none.</u>	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>none.</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none.</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <u>none.</u>			
2. I hereby certify that I attended the deceased from <u>12-3</u> , 1951, to <u>3-23</u> , 1955, that I last saw the deceased alive on <u>3-22</u> , 1955, and that death occurred at <u>3 P. M.</u> from the causes and on the date stated above.			
SIGNATURE <u>D. D. Caples</u>		ADDRESS <u>Reisterstown, Md</u> DATE SIGNED <u>3-24-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-26-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Black Rock</u>		LOCATION (City, town, or county) (State) <u>Butler, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-26-55</u>		REGISTRAR'S SIGNATURE <u>May B. Elina</u>	
24. FUNERAL DIRECTOR <u>Brooks Funeral Home, Sparks, Md.</u>		ADDRESS <u>14001 Brook</u>	

THE UNIVERSITY OF CHICAGO

1950-1951

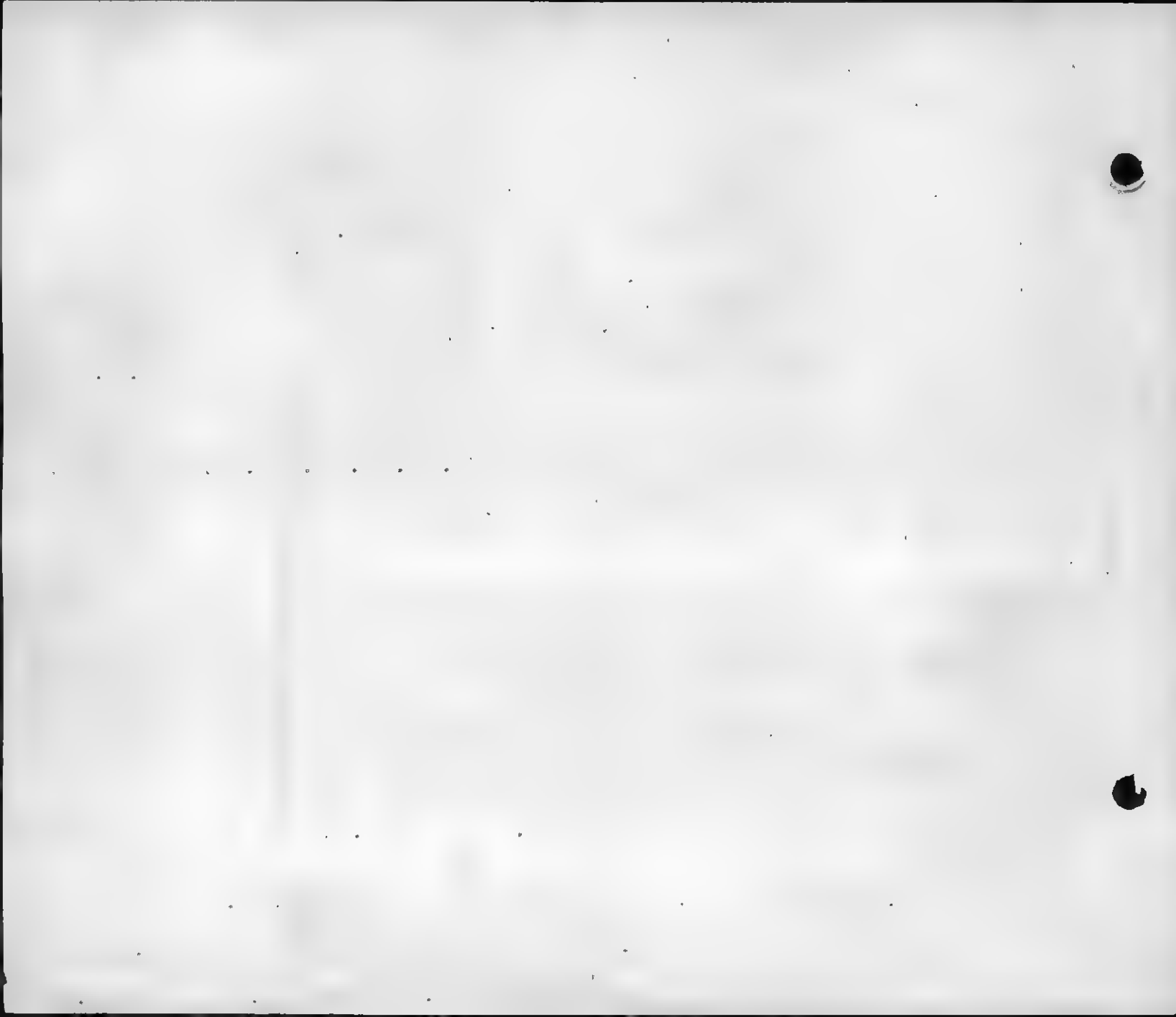
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 102468

## 2482 CERTIFICATE OF DEATH

Reg. Dist. No. *102468*

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>9 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>622 Lee Street</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>622 W. Lee Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>JAMES E. WHITE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 28 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>March 4, 1920</u>	9. AGE last birthday <u>35</u> yrs	10. UNDER 1 YEAR: Months Days	11. UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Car Cleaner</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Garage</u>		11. BIRTHPLACE (State or foreign country): <u>Applee, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Nathan White</u>				14. MOTHER'S MAIDEN NAME: <u>Druscilla Carpenter</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW-II</u>		16. SOCIAL SECURITY NO. <u>212 16-2921</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp. Fort Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						UNKNOWN	
156.1 IMMEDIATE CAUSE (A) <u>CARCINOMA OF LIVER</u> DUE TO							
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 19, 1955</u> , to <u>Mar. 28, 1955</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William B. VandeGrift, M. D.</u>		ADDRESS <u>M. D. VAH, Fort Howard, Md. 3-29-55</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-1-55</u>		NAME OF CEMETERY OR CREMATORY <u>St. John's Methodist Cemetery</u>		LOCATION (City, town, or county) (State) <u>Calvert County, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-22-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Isaiah Brown &amp; Son Funeral Home</u> <u>108 W. Montgomery St., Baltimore, Md.</u>			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: Please write the causes of death clearly and legibly.

2483

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

02469

Reg. Dist. No. 43

1. PLACE OF DEATH COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>X</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5 Greenwood Ave</u>		STREET ADDRESS (If rural, give location) <u>5 Greenwood Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Robert D</u> (Middle) <u>Whiteford</u> (Last)	4. DATE OF DEATH (Month) <u>March</u> (Day) <u>8</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>Aug 2-1874</u>
9. AGE last birthday <u>80 yrs.</u>		10. UNDER 1 year Months <u>00</u> Days <u>00</u>	11. UNDER 24 hrs. Hours <u>00</u> Mins. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>maintenace man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto City Employee</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto City md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>George Whiteford</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Mrs Russell Huntington 5 Greenwood Ave</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>334X</u> Immediate cause (a) <u>Cerebral arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office hldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept</u> , 19 <u>54</u> , to <u>March 8</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>March 4</u> , 19 <u>55</u> , and that death occurred at <u>4 A.</u> m., from the causes and on the date stated above.			
SIGNATURE: <u>[Signature]</u>		ADDRESS: <u>H.A.</u> DATE SIGNED: <u>[Signature]</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	
<u>Burial</u>		<u>3/11/55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Oak Lawn Cem</u>		<u>Balto md</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>Mar 9-1955 Mrs. M. D. Reifner</u>		<u>Lassalle Funeral Home 7401 Balto Rd</u>	

BUREAU V. S.

MAR 11 1961

RECEIVED



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2484

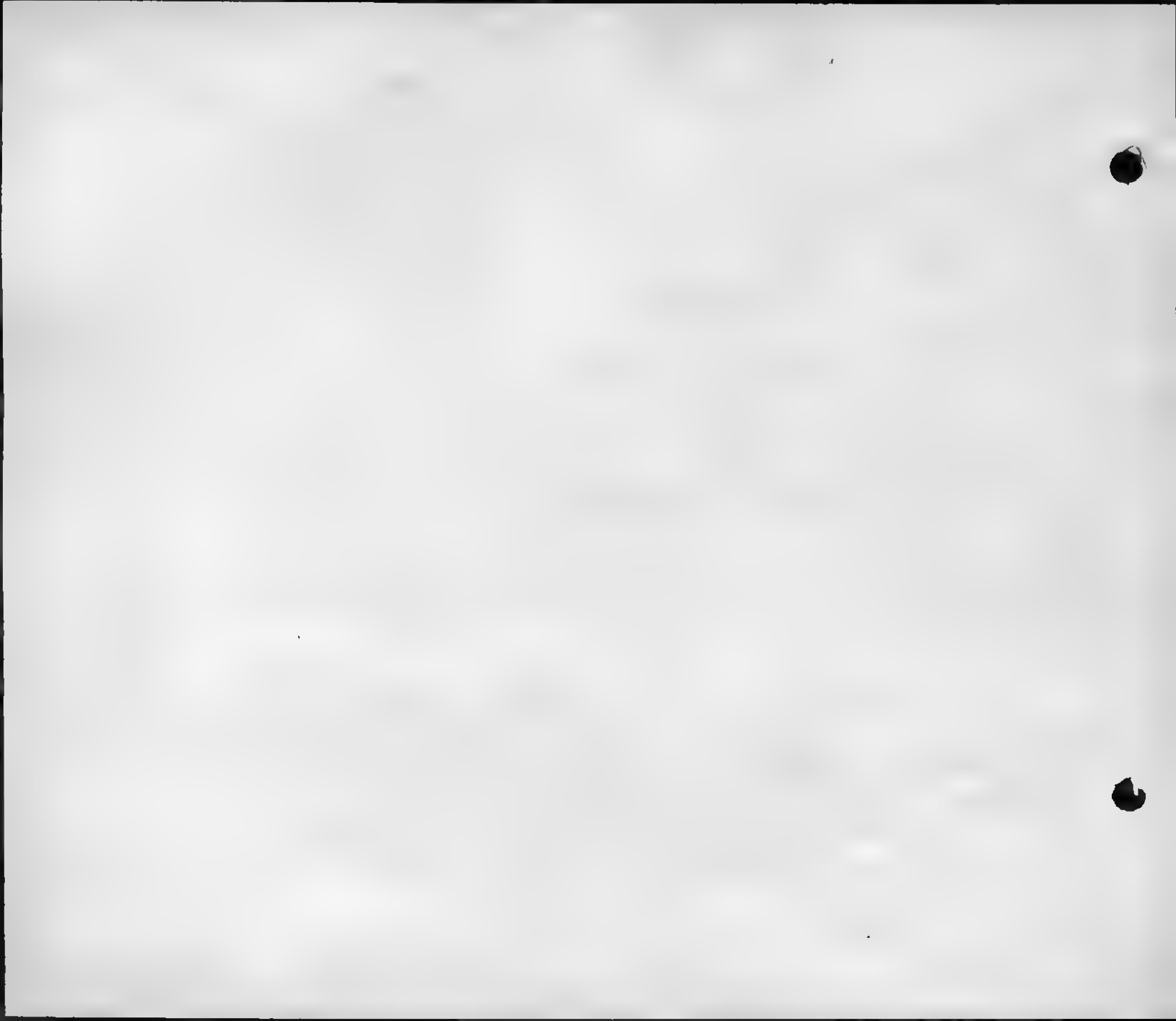
## CERTIFICATE OF DEATH

Reg. Dist. No.

02470

38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X <u>Satyr Hill</u>				<u>Balto</u>		3. <u>+</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Shanklin Road</u>				STREET ADDRESS (If rural give location) <u>1142 + Knowles St</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>James C Whitlow</u>				OF DEATH <u>March 20, 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>Oct. 26, 1886</u>	9. AGE last birthday IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days
				<u>68</u> yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Bookkeeper</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>England</u>	
13. FATHER'S NAME: <u>Joseph Whitlow</u>				14. MOTHER'S MAIDEN NAME: <u>Katherine Elavel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.: <u>212-18-8805</u>		17. INFORMANT & ADDRESS: <u>Sarahann Whitlow, Satyr Hill</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
158x IMMEDIATE CAUSE (A) <u>Carcinoid Carcinoma</u>						7 Days	
ANTECEDENT CAUSE (B) <u>Intestinal Obstruction</u>						2.15.55	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Gastric Neurosis</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		<u>Metastatic Ca of Liver Peritoneum</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/1</u> , 1955 to <u>3/20</u> , 1955, that I last saw the deceased alive on <u>3/20</u> , 1955, and that death occurred at <u>10<sup>00</sup></u> M, from the causes and on the date stated above.							
SIGNATURE <u>William J. Park</u>		M.D.		ADDRESS <u>700 N. Charles</u>		DATE SIGNED <u>June 3, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>cremation</u>		<u>3/23/55</u>		<u>Green Mount Crematory, Baltimore</u>		<u>726</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3/23/55</u>		<u>Wm. J. Park</u>		<u>Wm. J. Park, Inc.</u>		<u>131246 Paul St</u>	



2485

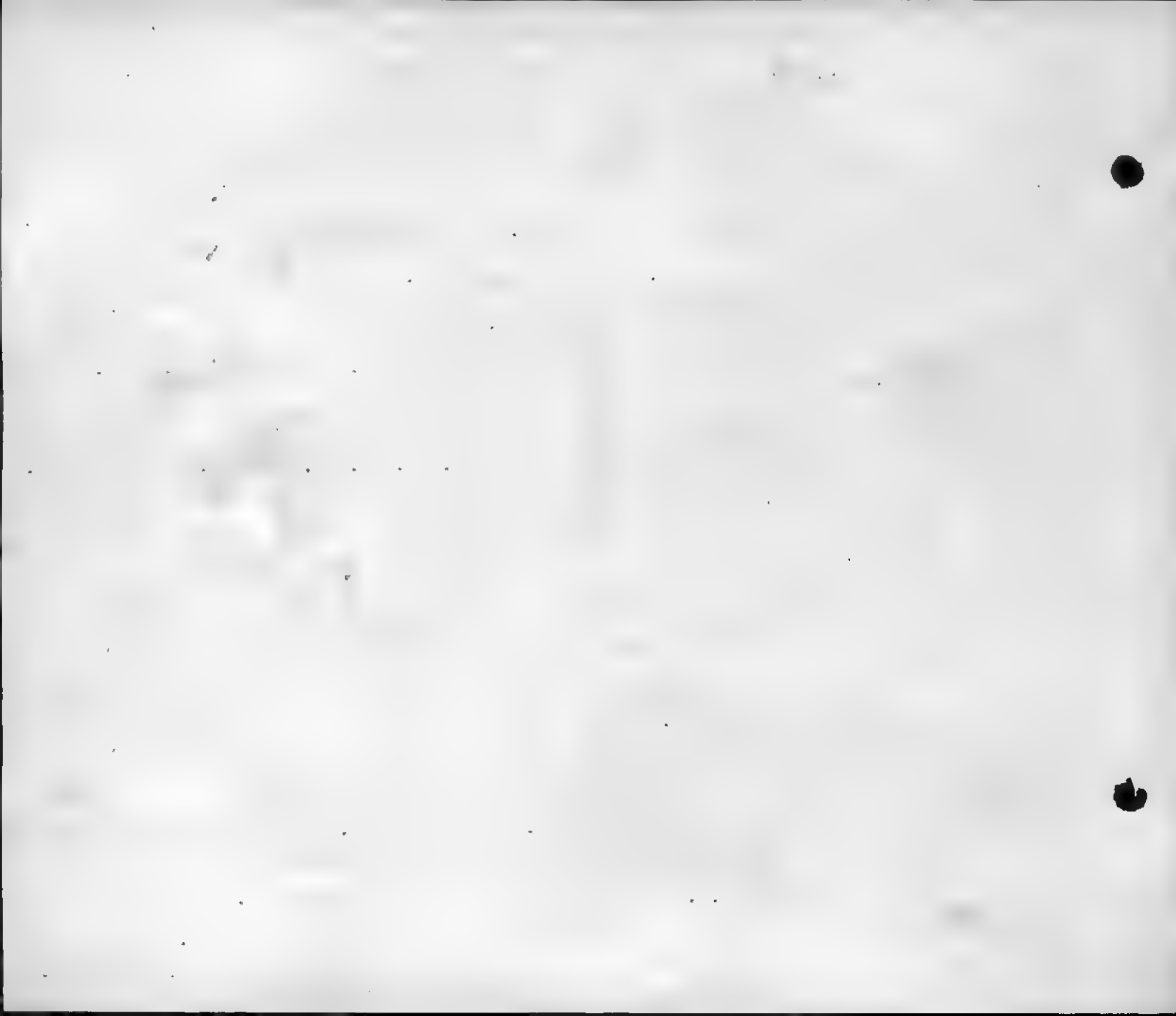
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Baltimore		MARYLAND	STATE	Maryland
CITY (If outside corporate limits, write RURAL or and give nearest town)	Fort Howard		LENGTH OF STAY (In this place)	15 Days	
CITY (If outside corporate limits, write RURAL or and give nearest town)	Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore (Catonsville)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural give location)		
Veterans Administration Hosp.			151 Winters Avenue		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE (Month) (Day) (Year) OF DEATH		
GEORGE W. WILLIAMS, SR.			March 8 1955		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months Days
Male	Colored	Married	April 19, 1896	58	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired):			11. BIRTHPLACE (State or foreign country):		
Self employed Storekeeper			Catonsville, Maryland		
13. FATHER'S NAME:			12. CITIZEN OF WHAT COUNTRY?		
Aden Williams			U. S. A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.		
Yes			Unknown		
17. INFORMANT & ADDRESS:			18. MEDICAL CERTIFICATION		
Clin. Rec. Vet. Adm. Hospital, Fort Howard, Md.			I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE			(A) CARCINOMA OF PROSTATE		
ANTECEDENT CAUSE (B)			DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			(B) DUE TO		
(C)			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			UNKNOWN		
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION		
3-3-55			Bilateral Orchidectomy		
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		
21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?			22. I hereby certify that I attended the deceased from Feb. 21, 1955, to Mar. 8, 1955, and that death occurred at 12:50 M, from the causes and on the date stated above.		
SIGNATURE			ADDRESS		
WILLIAM B. VANDEGRIFT, M.D.			M. O. VAH, Fort Howard, Md.		
DATE SIGNED			DATE SIGNED		
3-9-55			3-9-55		
23. BURIAL, CREMATION, REMOVAL (SPECIFY)			DATE THEREOF		
Burial			3-14-55		
NAME OF CEMETERY OR CREMATORY			LOCATION (City, town, or county) (State)		
Baltimore National			Baltimore, Maryland		
DATE REC'D BY LOCAL REGISTRAR			24. FUNERAL DIRECTOR ADDRESS		
REGISTRAR'S SIGNATURE			Hemsley Funeral Home, 578 W. Biddle St. Baltimore, Maryland		

MARGIN RESERVED FOR PRINTING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



02472

MARYLAND 2486

STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>...</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>...</u> <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>...</u>		STREET ADDRESS (If rural, give location) <u>...</u>	
3. NAME OF DECEASED (Type or Print) <u>VERNON</u> (First) <u>L. O. J.</u> (Middle) <u>...</u> (Last)		4. DATE OF DEATH (Month) <u>...</u> (Day) <u>...</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>...</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>...</u>	8. DATE OF BIRTH <u>...</u>
9. AGE last birthday <u>...</u> yrs.		10. If under 1 year Months <u>...</u> Days <u>...</u> Hours <u>...</u> Min <u>...</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>...</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ship Yard</u>	
11. BIRTHPLACE (State or foreign country) <u>...</u>		12. CITIZEN OF WHAT COUNTRY? <u>...</u>	
13. FATHER'S NAME <u>...</u>		14. MOTHER'S MAIDEN NAME <u>...</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) (If year, give war or dates of service) <u>...</u>		16. SOCIAL SECURITY No. <u>...</u>	
17. INFORMANT AND ADDRESS <u>...</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>...</u>	
581.0 Immediate cause (a)...					
Antecedent cause(s) (b)...					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)...					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>...</u>	

22. I hereby certify that I attended the deceased from ..., 1955, to ..., 1955, that I last saw the deceased alive on ..., 1955, and that death occurred at ... 3:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>March 24-1955</u>	<u>Old Saints</u>	<u>Reisterstown, Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3-23-55</u>	<u>A. H. ...</u>	<u>George Funeral Home</u>	<u>3631 Falls Road</u>	
		<u>Horace F. Curgee</u>		

MARGIN RESERVED FOR BINDING



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

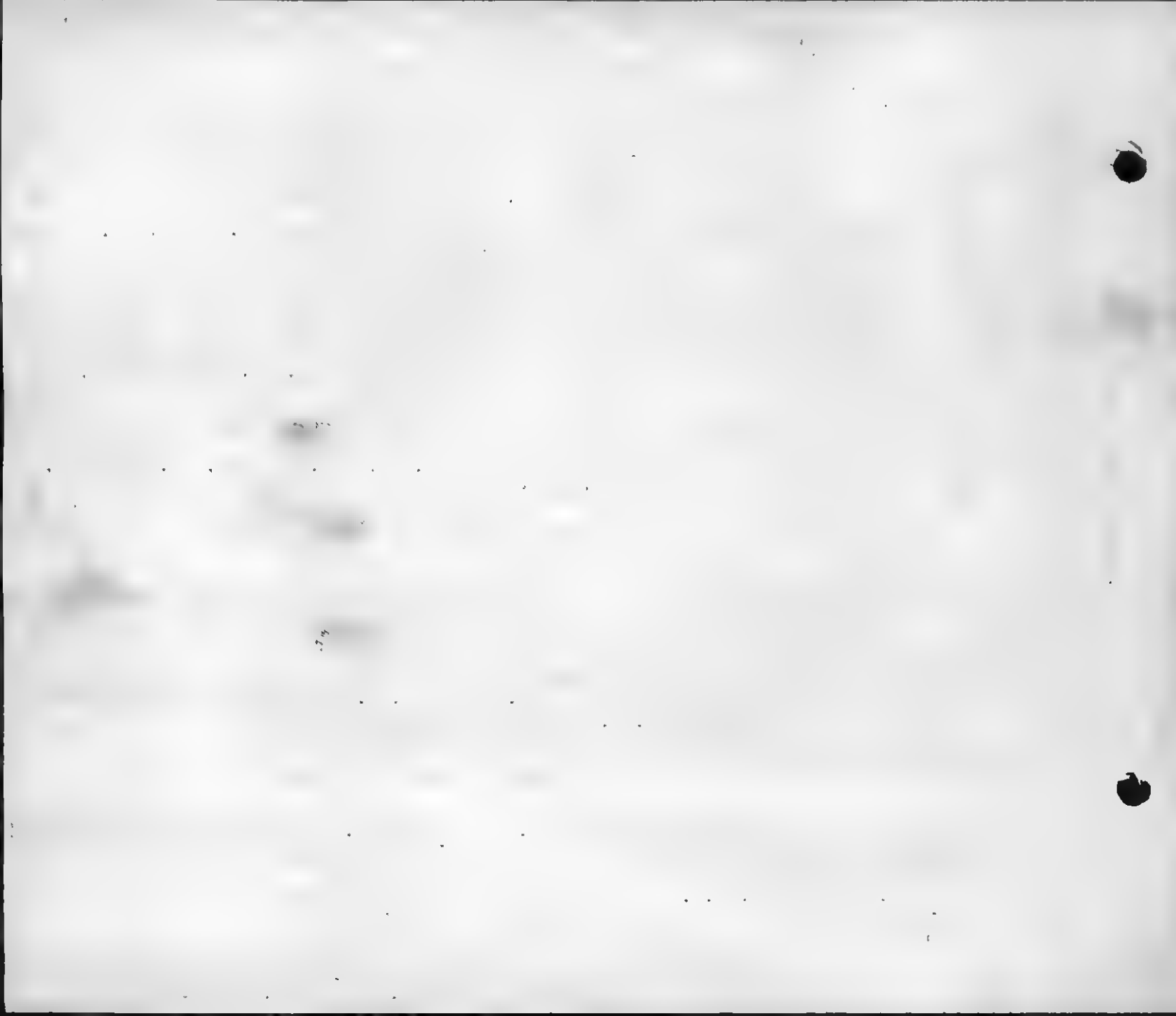
02473

2487

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort Howard</u>		<u>70 Days</u>		OR TOWN <u>Baltimore</u> <u>2401-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1705 1/2 Brunt St., Balto., Md.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <u>ROBERT</u> (NMI) <u>WILLIS</u>				OF DEATH: <u>March 6,</u> <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>5/2/95</u>	
9. AGE last birthday: <u>59</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>		11. BIRTHPLACE (State or foreign country): <u>Charles City Co., Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Joseph Willis</u>				14. MOTHER'S MAIDEN NAME: <u>Mirah MN: Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WWI</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						UNKNOWN	
IMMEDIATE CAUSE (A) <u>443X</u> <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>1-20-55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>A.K. Amputation, left leg. Findings. 1. Dry gangrene, left lower leg. 2. Occlusion of popliteal artery</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, etc.) OF INJURY street, office bldg., etc.		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> <u>M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 26, 1954, to Mar. 6, 1955, and that death occurred at 9:15 M, from the causes and on the date stated above.							
SIGNATURE <u>William B. Vandegrief, M.D.</u>				ADDRESS <u>M. D. VAH, FORT HOWARD, MARYLAND</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/10/55</u>		<u>Baltimore National</u>		<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-10-55</u>		REGISTRAR'S SIGNATURE <u>A W Hedrick</u>		24. FUNERAL DIRECTOR		ADDRESS	
				<u>Arlington S. Phillips Funeral Home</u>		<u>1808 N. Monroe St., Balto., Maryland</u>	





2488

## CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>White Hall (Rural)</u>	<u>40 yrs.</u>	TOWN <u>White Hall, (Rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>Draystone Rd</u>		<u>Draystone</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Delia Myrtle Wilson</u>		DATE OF DEATH: <u>Mar. 10 19 55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<u>F</u>	<u>W</u>	<u>unmarried</u>	<u>3-16-1894</u>
9. AGE last birthday: <u>60</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>laborer</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Samuel Hoover</u>		14. MOTHER'S MAIDEN NAME: <u>Elise Lee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-24-8317</u>	
<u>no</u>		17. INFORMANT & ADDRESS: <u>Mrs. Leonard Wilson, White Hall, Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>			<u>15 min.</u>
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22 I hereby certify that I attended the deceased from <u>1945</u> , to <u>3/10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/9</u> , 19 <u>55</u> , and that death occurred at <u>1 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>D. M. France</u>		M. D. <u>Parleton Ind</u> DATE SIGNED <u>3/10/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>3-17-55</u>	
NAME OF CEMETERY, OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>West Liberty Methodist</u>		<u>White Hall, Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>3/12/55</u>		<u>Mrs. Howard S. M. ...</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Brooklyn Funeral Home, Sparks, Md</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 15 1955

BUREAU V. S.

02475

MARYLAND 2489

STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Md.</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Glyndon</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Glyndon</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Sacred Heart Lane</b>		STREET ADDRESS (If rural, give location) <b>Sacred Heart Lane</b>	
3. NAME OF DECEASED (Type or Print) <b>Pearl</b> (First) <b>V</b> (Middle) <b>Wimple</b> (Last)		4. DATE OF DEATH <b>March 28, 1955</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>April 10, 1881</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <b>73</b> yrs.
11. BIRTH PLACE (State or foreign country) <b>Baltimore County</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James Neal</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY No. <b>None</b>	
17. INFORMANT AND ADDRESS <b>Russell Wimple, Glyndon, Md.</b>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause

(a) **Coronary Thrombosis**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Arteriosclerotic C.V. Disease**

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## INTERVAL BETWEEN ONSET AND DEATH

3 mos.

5 yrs.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **Jane**, 19**48**, to **March 28, 1955**, that I last saw the deceasedalive on **March 28, 1955**, and that death occurred at **11:00 P.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

**Martin E. Strobel****M.D.****Reisterstown, Md.****3/29/55**

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<b>Burial</b>	<b>April 1, 1955</b>	<b>Piney Grove</b>	<b>Baltimore County</b>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<b>3-30-55</b>	<b>Mary B. Eline</b>	<b>J.F. Eline &amp; Sons</b>	<b>Reisterstown, Md.</b>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

APR 1 1965

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2319

CERTIFICATE OF DEATH

Reg. Dist. No.

02476

41

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> TOWN <u>Dundalk</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Balt.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> TOWN <u>Dundalk</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1531 Leslie Ave.</u>		STREET ADDRESS (If rural give location) <u>1531 Leslie Ave.</u>	

3. NAME OF DECEASED: (Type or Print) <u>ISABEL</u> (First) <u>E.</u> (Middle) <u>WOOLFORD</u> (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <u>Mar. 4,</u> <u>19 55</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH: <u>Sept. 30, 1917</u>
9. AGE last birthday <u>37</u> yrs.		10. AGE last birthday IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Frederick W. Hippler</u>		14. MOTHER'S MAIDEN NAME: <u>Blanche Innerst</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Mr. Dixon R. Woolford-1531 Leslie Ave.</u>			

18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>744.1</u> IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(A) <u>Aspiration Pneumonia</u> DUE TO (B) <u>Progressive Muscular</u> DUE TO (C) <u>Dystrophy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>16 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from July, 1952, to March, 1955, that I last saw the deceased alive on March 3, 1955, and that death occurred at 7 a M, from the causes and on the date stated above.

SIGNATURE John R. Collins Harvey ADDRESS 410 Kottway DATE SIGNED March 3, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial DATE THEREOF 3/8/55 NAME OF CEMETERY OR CREMATORY Loudon Park Cem. LOCATION (City, town, or county) (State) Balto., Md.

DATE REC'D BY LOCAL REGISTRAR <u>3-7-55</u>	REGISTRAR'S SIGNATURE <u>LL</u>	24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner</u>	ADDRESS <u>1814 17th St</u>
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MARGIN RESERVED FOR BINDING

VS. A15 -- 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

